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ABSTRACT

Described is the establishment in New York City of a center for multiply handicapped children. In addition to a project summary, provided are twenty-five selections written by various staff members which focus on such topics as the role of the special education coordinator; selection, intake screening, and evaluation; the medical program; the role of the paraprofessional; experiences of a student teacher; taxonomic instruction; review of reading materials; adaptation of a social learning curriculum; speech and language programs; a class tribute to Dr. Martin Luther King; music activities; puppetry; the roles of social workers, guidance counselors, physical therapists and occupational therapists. (CL)

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THE
ESTABLISHMENT
# of a
CENTER for
MULTIPLE-HANDICAPPED
CHILDREN

"FROM IDEA TO REALITY"

Division of Special Education & Pupil Personnel Services

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FOREWORD

The Multiple Handicapped Center represents the hope that every handicapped child in New York City receive the full education, support and compassionate care that he deserves.

As the dream for this very special population of children became reality, we saw visible proof that all our handicapped children could be helped to achieve their potential as happy, contributing human beings. Creative planning, sound professionalism and loving concern have made this possible.

The Center is a model that points toward a better future for all our children.

Dr. Helen M. Feulner,
Executive Director
Division of Special Education
And Pupil Personnel Services

PREFACE

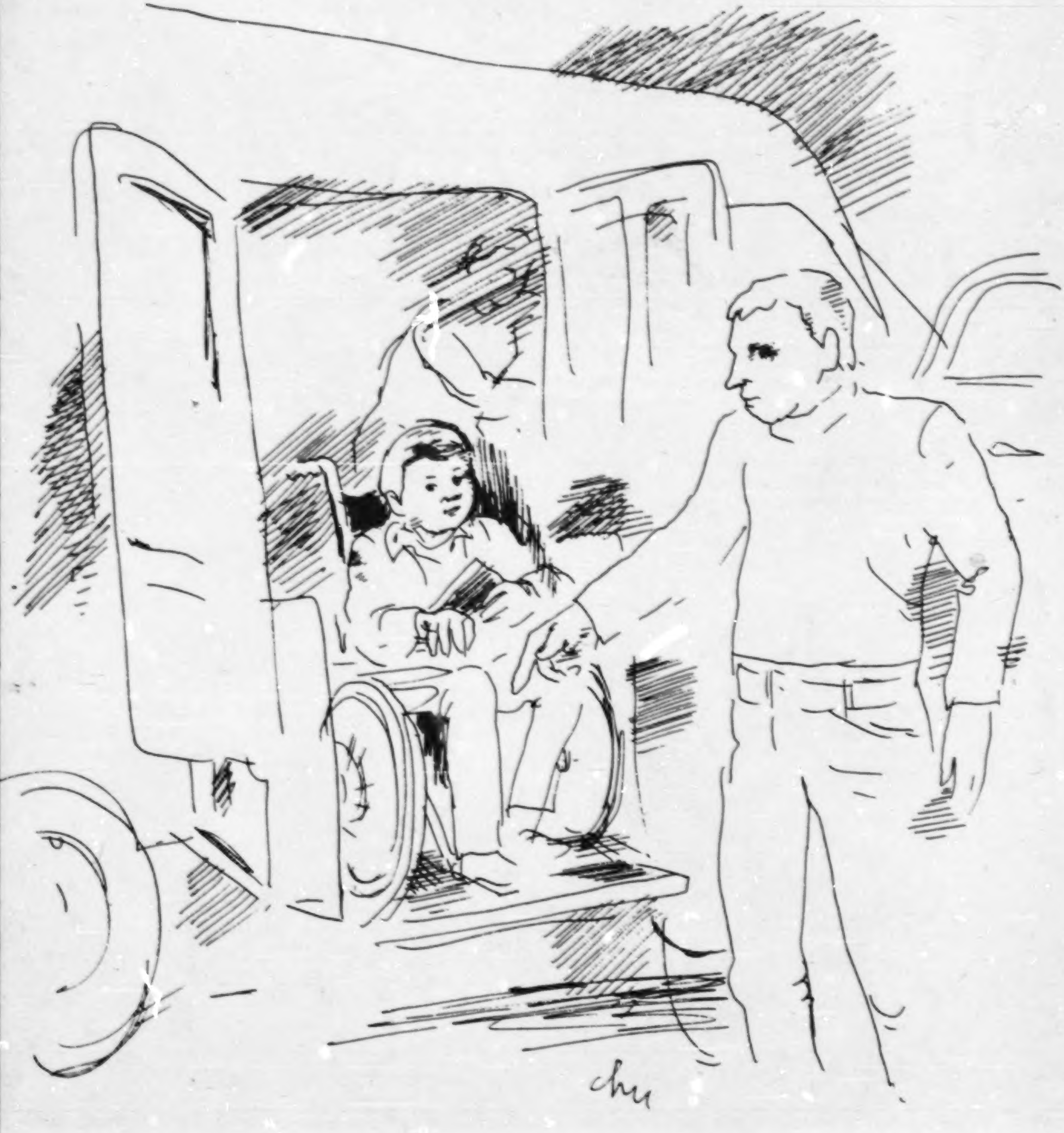
At the beginning of this descriptive report, a word of thanks is due to Mr. Richard Lubell during whose superintendency the Center for Multiple-Handicapped Children was initiated; to Mrs. Helen M. Feulner, Executive Director (DSEPPS) who made straight the path in helping to make the idea a reality and coordinated the many stages of development; to Miss Madeline E. Dalton, Director Bureau for Children with Retarded Mental Development, who prepared the original proposal and motivated many educational innovations; to Dr. Donna O'Hare, Assistant Commissioner, Department of Health for her leadership and guidance as Chairman of the Advisory Committee; to the parents and children who have given meaning and life to the entire program; to the staff which was willing to take a step into the educational unknown because they cared; and to E.S.E.A., Title III which made it all possible.

ACKNOWLEDGEMENTS

Special thanks are due to all the members of the staff whose assistance in the preparation of this manuscript has been most outstanding. Their contributions will help other special educators understand the nature of our children and program and may provide the motivation to establish other Centers throughout the nation.

The Center is especially grateful to Dr. Allan Schulps, Special Education Coordinator, for editing and proofreading the entire manuscript. Many hours were spent on this task and his assistance and cooperation have been invaluable.

Mrs. Lola Dawkins, Miss Brenda Raiford and Mrs. Rita Washington of the Center's office staff typed the manuscript and prepared it for the printer. Mr. Philip Chu, teacher, prepared the pen and ink drawings and Mr. Samuel Teicher photographed the activities of the children. Grateful acknowledgement is made for their efforts that helped make the idea become a reality.



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THAT SAME SPIRIT LIVES TODAY

EDWARD HAND, First President of the Center's Parents Association.

Parents Associations have been in existence for so very many years one might be hard-pressed to describe any such organization as "unique". A brief history of our group will, I'm hopeful, illustrate that the task of applying this term to the Parents Association of the Center for Multiple-Handicapped Children is not a difficult one.

The Center for Multiple-Handicapped Children was, in and of itself, unusual. It was experimental in nature and the only facility of its kind in the country. Federally-funded under a Title III grant, it was scheduled for Tax Levy funding in 1972. While there was a myriad of administrative and functional problems related to the establishment of the Center, these problems were met and resolved in a most professional and efficient manner by those dedicated to the project. Every goal, every hope that for the first time the needs of multiple-handicapped children would be served was achieved by the Center. Admittedly, much remained to be done, for the surface had just been scratched, but the seed had been planted, was flourishing, and things were going along beautifully.

It was in this atmosphere that the Parents Association was born. While this atmosphere was ideal, the problems to be confronted were many. It is never an easy task to organize a parents group at a new facility but we had some unusual problems.

The entire student population numbered 128. We did not therefore have large numbers of parents to draw from. Some of the students were from foster homes further reducing our numbers. Parent involvement in community and school activities was limited due to demands on the parents' time in caring for their handicapped children. Experience then, was for all practical purposes, non-existent. Add to this, the fact that the Center located in Manhattan, served children from all five boroughs and all 31 school districts and try to visualize transportation and time problems faced by parents just to attend a meeting.

Were these problems insurmountable? Of course not; but they were problems over and above the norm. However, just as the founders and staff of the Center met and resolved their problems in their new venture, the parents faced and resolved theirs. We had one advantage though - the help, guidance and unbelievable dedication of these professionals. As with the Center itself, so it was with the infant Parent Association. The seed had been planted, was flourishing, and things were going along beautifully until---.

Word filtered down to the Staff and Parents that the Center had, by name, been deleted from the Mayor's Budget Message. What exactly did this mean? Quite simply, Federal Funds had been exhausted and were not renewable. Failure of the City to transfer the Center to Tax Levy rolls as planned, and this is what deletion from the Mayor's Budget meant, would result in the closing of the Center. No one could believe this was happening. It was not a question of transferring our children to another school for there was no other school for them. There must be a mistake. Unfortunately, it was not a mistake - the Center was closing.

Something had to be done, but what? How could such a small group of inexperienced people mount an effort that would offer even the slightest ray of hope? Sympathetic friends of the Center, who were experienced, reluctantly but realistically, advised that the task was next to impossible. It was quickly decided that the education and future of our children was deserving of our total effort regardless of the futility of that effort.

With the exception of those directly associated with our school, few people had ever heard of the Center for Multiple-Handicapped Children. To overcome this deficiency, a two-pronged effort was launched. First came the publicity. News conferences were called at the Center with polical figures and the media invited. As a result of telephone, telegram and personal contacts briefly describing our plight, the response from both fields was excellent. Once our story reached the TV screens and newspapers, things started to happen. TV stations reported record numbers of calls from the public expressing shock and dismay with the plan to close the Center. Follow-up TV interviews took place at the Center with figures in the political and educational fields, parents, teachers and the children themselves. A special TV segment was filmed at the home of a multiple-handicapped child to illustrate the reaction and effect closing of the Center was having on a family unit. Public response continued to rise and suddenly, the Center for Multiple-Handicapped Children was no longer an unknown entity.

Our second effort keyed in on one firm belief shared by all. It is impossible for anyone to visit the Center, observe and talk to children and staff and walk away without feeling they have witnessed a true "first" in the area of education for the handicapped. The experience leaves the visitor with a warm feeling of satisfaction, love and concern that is difficult to describe. Since these sentiments were so often expressed, we invited as many people as possible to share this experience. The people came. When they left, we knew we had another friend who would support us in our time of need.

The culmination of our efforts took place on May 2, 1972 when a group of parents and staff from the Center spoke at the N.Y.C. Board of Estimate Public Hearing. Anyone having attended such a hearing will attest to their nature. Noisy, vociferous, vitriolic and often disorderly. Such was not the case during our presentation. There was rapt attention, not a sound was heard in the Chamber as the parents' spoke.. Their individual pleas were unrehearsed, unprofessional and with little reference made to the legal rights of their children. They just spoke from their hearts in very simple terms, explaining what the Center meant to their child and pleaded for the support of the Board of Estimate.

The Center did not close. It thrives today and will be expanded, all because a group of parents, "unique" by virtue of their small number and inexperience, were willing to fight an impossible fight for the love of their children.

Names were intentionally omitted from this narrative, for to name individuals could give rise to the thought that those involved were desirous of credit or praise for their efforts. Not one person, regardless of their degree of involvement, whether parent, teacher, politician or friend, ever considered anything but their love and concern for the children. It was this spirit that won the battle and that same spirit lives today.

A GRADUATE SPEAKS:

Gregory Doboshinski

I graduated in June 1973.

I go to Westinghouse High School.

I am doing well in school.

I come back two or three times a year to visit my teacher at the Center.

We give a party for our teacher every year so we can visit her.

We like her.

PROJECT DESCRIPTION

Dr. Edmund M. Horan, Project Director

PROJECT DESCRIPTION

1. Motivation that encouraged New York City Board of Education to apply for ESEA Title III funding.

The Center for Multiple-Handicapped Children was conceived as an idea in February of 1968. At that time members of the Division of Special Education and Pupil Personnel Services (DSEPPS) of the New York City Board of Education met with representatives of non-public schools and Title III, E.S.E.A. personnel. The purpose of the meeting was to reach a consensus on a recommendation of the highest priority need for a proposal made possible by funds provided by Title III, E.S.E.A. It was unanimously agreed that the education and habilitation of multiple-handicapped children was a serious, unsolved problem for all the special education bureaus and for the non-public school agencies working with handicapped children.

Today as a result of that meeting in 1968, children with multiple-handicaps are receiving a total program of education and habilitation in New York City under the jurisdiction of the New York City Board of Education because the idea to educate these children was ready to be tried. However, in order to implement this idea a source of funding was necessary and this source was found on January 17, 1969 through Title III of the Elementary and Secondary Education Act. Through this funding the idea for a Center for Multiple-Handicapped Children was able to become a reality. Since July 1, 1972 it continues so under tax-levy funds after 42 months of federal funding which terminated on June 30, 1972.

The establishment of a Center for Multiple-Handicapped Children provided the first public school facility for total and coordinated services for multiple-handicapped children in New York City.

Although the CMHC was conceived as an idea in February of 1968, the realization of the need for such a Center in New York City goes farther back in time.

Recognizing the urgency for developing school placement facilities for an increasing number of children with combinations of handicaps requiring specialized facilities and the competencies of more specialized personnel than any combination of existing programs could supply, the Office of Special Education and Pupil Personnel Services organized in 1961 an interdepartmental committee with representatives from specialized community agencies to deal with the problems of the educational placement of multiple-handicapped children.

For seven years, meeting once a month, this committee reviewed cases of multiple-handicapped pupils who could not be sustained in any existing special program without additional supportive services. When necessary, individual cases were further referred to a special screening team (including a Pediatric Neurologist, Psychiatrist, Psychologist, Psychiatric Social Worker, Supervisors of OSEPPS, and other specialists as needed). Whenever possible, total resources of all committee members were coordinated to effect specialized school placements.

Eventually, a special class was established in a school where a number of inter-disciplinary services could be utilized for a limited number of multiple-handicapped pupils. The intensive individualized program and services provided in this class made it possible for a number of these multiple-handicapped pupils to find permanent placement in other existing special classes in regular public schools.

It was proved that children with multiple-handicaps who had been in educational limbo were able, after an intensive individualized program, to be placed in special education classes. These educational pioneers had made an important discovery but funds were then lacking to expand the concept. However, in February of 1968, a source of funding became available through Title III, E.S.E.A. As a result of this funding the Office of Special Education and Pupil Personnel Services of the New York City Board of Education unanimously agreed to establish a Center for Multiple-Handicapped Children. Miss Madeline Dalton, Director of the Bureau for Children with Retarded Mental Development (BCRMD), coordinated the preparation and writing of the Proposal and originated many of the innovative features of the program. Mrs. Ida Silver, Coordinator of Reimbursable Programs, gathered pertinent information for the Proposal from each of the Bureaus of the Office of Special Education and Pupil Personnel Services.

2. GENERAL PURPOSE OF THE PROJECT

This Center was designed to serve as a model for the establishment of similar services for multiple-handicapped children in other communities; a demonstration school; a center for training in inter-disciplinary competencies; a source for the innovation of improved educational methods and techniques; a research laboratory and a focal point for "satellite services" in other boroughs of New York City.

3. PLANNING PHASE

On March 17, 1969, Richard Lubell, Assistant Superintendent of the Office of Special Education and Pupil Personnel Services, appointed Edmund M. Horan as Project Director and Gerald Ehrlich as Assistant Project Director. An immediate priority was the selection of a specific building for the Center for Multiple-Handicapped Children. After inspecting several possible sites during the Spring of 1969, it was agreed that the site at 105 East 106th Street in Manhattan, subject to renovation, met most, if not all of the requirements of a multi-disciplinary educational program. The immediate neighborhood contained a hospital and emergency facilities for handicapped children. The site was on ground level and covered an area of 24,000 square feet. We learned that Hunter College of the City University of New York intended to lease the second floor of the building for a program to educate physical therapists, audiologists, and speech therapists in an Institute of Health Sciences. Buses transporting the children could enter and leave the building directly from Park Avenue by means of a sheltered loading area. Because of the site's central location and accessibility a greater number of multiple-handicapped children could be transported for services.

Blueprints were completed for the floor area, including specifications for necessary renovations. They were transmitted through the Division of School Planning and Research to the Department of Real Estate and to the landlord of the property. Negotiations were started on the actual leasing and renovation of the property. The blueprints provided a facility to meet the physical, educational, psychological and social needs of the children and adequate space was provided for the needs and comfort of parents, professionals, secretarial staff, para-professionals, teacher-trainees, and visitors. Several large rooms were designated as multi-purpose rooms - a combined lunchroom, auditorium and gym, and a combined library and conference room.

The Directors of the Bureaus of the Office of Special Education and Pupil Personnel Services provided lists of equipment and materials found to be appropriate and functional in the educational programs under their jurisdiction.

A survey of "Furniture List Items" provided by the Bureau of Supplies afforded assistance both as to the availability of certain types of equipment as well as information on unit costs. As an indication of the approach that was taken in this area, we ordered motorized doors for therapy rooms to afford easy entrance and exit for non-ambulatory children (later this order was rescinded since the need was not a real one), corridors and wash rooms were planned with special hand rails for the safety and comfort of the children, and carpeting was ordered for the early childhood rooms. Members of the staff of the School Planning and Research Division inspected the premises and reported that they were suitable for Board of Education purposes. On May 13, 1969 the Board of Education recommended that the premises be leased for a period of five years and that the lease include both a renewal and a cancellation clause. Prior to the beginning of the renovation of the Center, staff members of the New York State Center on Innovation in Education and the Division for Handicapped Children inspected the site.

The position of Special Education Coordinator was placed in the new budget for the operational phase and candidates were interviewed for this position on December 16, 1969. Dr. Allan Schulps, Supervisor, Bureau for the Education of Physically Handicapped Children, was selected for this position. Staff recruitment began during the Autumn of 1969. Bureau Directors of OSEPPS were very cooperative in offering the services of licensed teachers and clinical personnel under their jurisdiction.

During the planning phase the development of an in-service training program for staff members was very much in our thoughts. Initially, we had hoped to install closed circuit television cameras in each classroom with a receiving console in the conference room. But the cost of this system was too high even for the many advantages for in-service training involved. Instead, observation corridors were placed in the blueprints in which the children in six classrooms and the therapy rooms could be observed and heard. A videocorder was purchased to tape intake and classroom procedures to be used in in-service training. Two consultants visited a number of educational sites with facilities for handicapped children and identified the most promising features of the programs they observed for serving these children. Their recommendations were included in our budgetary requirements for classrooms, clinical and medical areas, and physical and occupational therapy rooms with particular emphasis on equipment and materials best suited to meet the needs of the multiple-handicapped child.

Liaison had been established prior to the actual planning phase with various committees representing both voluntary and professional agencies and community groups. The Advisory Committee for Federally Funded Programs for Handicapped Children had met four times during the planning phase of the Center and received progress reports dating from the Letter of Intent Stage. One organizational outcome of these meetings was the decision to form a core committee of three medical doctors and one educator to gather information on the number of multiple-handicapped children living in New York City and the nature of required services to meet their needs. Dr. Alfred Scherzer served on this core committee and later became the Medical Director of the Center for Multiple-Handicapped Children. In addition to information gathered from hospitals with pediatric clinics, the Directors of Bureaus of OSEPPS were requested to assist in gathering prevalence figures of multiple-handicapped children, and a careful screening was performed of children whose parents had applied for educational services under P.L. 4407. The core committee was also requested to submit a report containing its recommendations for eligibility criteria, initial screening and intake, and referral procedures. Available to this core committee were the recommendations in these areas of the Directors of the Bureaus of OSEPPS. We were all very much aware during the planning phase of the need to develop a total profile for educational evaluation and placement of each child with appropriate procedures and schedules for testing and observing, team interaction, parent consultation, and medical evaluation referral follow-up at the Center; but the actual development of the Individual Educational Profile was not completed by the staff till late in 1970. Since that time a manual has been prepared by the Center's Psychologists to be used with the instrument and the Profile itself has been refined and made more functional in several areas by actual use at the Center.

During the planning phase, discussions were held with representatives of several local colleges and universities to explore the means by which services could be offered to develop appropriate programs for teacher training, specialized research, curriculum design and specialized learning theory. A decision was made to be eclectic in the selection of curriculum rather than to initiate the program at the Center with a preconceived approach to the curriculum. Several motivations were inherent in this decision. On the one hand we were aware that not enough was known about the multiple-handicapped child to warrant the selection of a specific curriculum at this stage of development, and, on the other hand, we wanted to maintain an openended approach and be free to make future selections based on the actual experience we all gained during the operational stage. In retrospect, we feel the decision made was proper and beneficial to both children and staff.

On October 23, 1969 the Board of Estimate of the City of New York approved the leasing of the Center's site at 105 East 106th Street, in New York City, for a term of five years from the date of occupancy with an option to the City to renew the lease for an additional five year period upon the terms and conditions as in the original lease. The lease was signed on January 8, 1970, and the demolition phase at the Center started immediately. The renovation was scheduled to be finished in November 1970. A contractual arrangement was established between the Board of Education (acting through and by the Center for Multiple-Handicapped Children) and New York Hospital, Cornell Medical College Clinic, to evaluate one hundred children before June 30, 1970 and an additional two hundred children during fiscal year 1970-1971. The evaluation was planned to include a medical, psychological, and educational screening. One hundred-thirty multiple-handicapped children were to be selected, after this evaluation, for admission to the Center while the remaining children were to be placed on a waiting list. The initial meeting at New York Hospital, Cornell Medical College, took place on February 27, 1970. At this meeting initial logistical arrangements were discussed with Professor Wallace McCrory, Chief of Pediatrics, Dr. Margaret Heagarty, Chief of Out-Patient Clinics, and Dr. Donna O'Hare, Director at that time of the Bureau for Handicapped Children, Department of Health. Subsequent meetings at Cornell Medical College were held on March 10 and March 17.

This contractual agreement afforded a means of involving the services of a hospital staff to establish qualified base lines on multiple-handicapped children to be used directly in educational prescriptions and their evaluation for effectiveness. The children already evaluated and found eligible for admission to the Center were scheduled to be admitted in late November, 1970. Additional staffing took place during September, 1970. Staffing was scheduled to be completed by January, 1971. The initial group of teachers was assigned as staff members to the Center on February 2, 1970 but was located, temporarily, at the Bureau for Children with Retarded Mental Development in Brooklyn while the demolition and renovation of the Center for Multiple-Handicapped Children was in progress. It was during this time that Mrs. Helen M. Feulner became the Acting Assistant Superintendent of the Office of Special Education and Pupil Personnel Services.

While situated at the Bureau CRMD the Center's staff made numerous visits to clinics, hospitals and schools throughout the city to become more familiar with the needs of multiple-handicapped children. They assisted in the paper screening of referrals to the Center, worked cooperatively on curriculum, assisted in preparing requisitions for equipment, supplies and materials. During the renovation period the teachers also visited the homes of children who had been admitted to the Center and offered home instruction to the children. Acting on a request made by Dr. Allan Schulps, Special Education coordinator of the Center for Multiple-Handicapped Children, Mr. Samuel Schweitzer, Principal of P.S. 199 Manhattan, established a class for some of the children while the renovation of the Center was in progress. Members of the Center's staff met with members of the East Harlem Community Corporation. We discussed community referral sources. The Center's administrative staff also met with representatives of community agencies of the East Harlem Community at a general meeting held at Flower-Fifth Avenue Hospital.

We visited the District Headquarters of School Districts 2 and 4 and explained the nature of the Center to personnel of these two districts. Referral letters were mailed city-wide to every school district, to every school guidance counselor, to Directors of Bureaus, to clinics and social agencies, to rehabilitation centers, parent organizations and community organizations.

During this period a Revised Evaluation of the Center was prepared by Dr. Leonard Blackman of Teachers College, Columbia University. At that time, Dr. Blackman and his staff were scheduled to conduct a complete evaluation of the Center and its program during the period from January 17, 1971 to January 16, 1972. As events turned out, the evaluation was actually begun in August of 1971 and was concluded during June, 1972.

Because of the fact that the renovation of the Center was not completed by November, 1970 we had to alter several aspects of the program. We were obliged to stop hiring a full staff because of the delay in renovation. As a result, funds for teacher's salaries were deobligated. Deobligated, also, were funds budgeted for transportation and food for the children. We also changed the thrust of program emphasis and placed it on the intake screening conducted at the Cornell Medical College Clinic.

The renovation delay, while being a setback to the Center's program, afforded the opportunity to obtain a complete screening of children to insure a full population for the Center by the end of 1970. The renovation delay also afforded the opportunity to select a staff of the highest competency.

It was gratifying to be able to enter into a contractual arrangement with Cornell Medical College, New York Hospital, for a complete medical, psychological, and educational screening of each child and to establish base line information structures on diagnosis at one clinic rather than on evaluations prepared by many separate clinics or individual physicians. For the first time to our knowledge, a hospital staff was directly involved in both the diagnosis and follow-up of a large population of multiple-handicapped children. Many possibilities for medical research are inherent in this approach.

The Advisory Committee was very helpful at the Center's monthly meetings in offering guidance for the many problems inherent in a project of this scope. The Advisory Committee as originally composed had on its staff medical personnel from the Department of Health, administrators of city-wide parent organizations, a representative from the Mayor's office, and representatives from religious denominations. It covered a broad spectrum of city agencies working with and for the handicapped child. The Committee helped to disseminate the Center's program throughout the City and State.

The response of referral agencies, including the New York City Board of Education, exceeded expectations. Nearly four hundred referrals of children to the Center were made through 1970.

The cooperation of E.S.E.A., Title III personnel in both New York City and Albany was appreciated very much. A great deal of guidance was offered the Center in planning, budgeting, and establishing evaluative systems. The Division of Special Education and Pupil Personnel Services of the New York City Board of Education and its Bureau Directors were most helpful in meeting teacher quotas and offering practical assistance.

The original target date for admitting the children to the Center had been March, 1970, but because of the delay in renovation the children were rescheduled for admission during November. Part of the renovation delay was caused by the fact that forty-nine holes (3' x 7') in the floor had to be filled with reinforced concrete. The holes had been made some years ago so that tanks used in producing motion pictures could be properly positioned. So the day the children got out of their buses and vans was not in November, 1970 but, rather, January 4, 1971. It was on that day that we could say that all the planning, all the preparation, all the frustration that had been involved in making an idea become a reality were worth it many times over.

4. ELIGIBILITY CRITERIA, REFERRALS, STUDENT POPULATION

The Center for Multiple-Handicapped Children, with a staff of teachers and clinical, medical para-medical and para-professional personnel offers an educational program and supportive services to multiple-handicapped children ranging from age five through seventeen.

Under the auspices of the Division of Special Education and Pupil Personnel Services (DSEPPS) of the Board of Education of the City of New York, the Center strives to achieve an optimal educational program through an integrated and coordinated multi-disciplinary approach. Intensive educational remediation and habilitative services and prescriptive teaching are some of the objectives.

The Center serves 128 children for whom busing is provided from all five boroughs. The eligibility criteria require that a child have multiple handicaps which may include neurological impairment, physical handicaps, and sensory disabilities in the areas of language, hearing and vision. Children in the full range of intelligence are acceptable. The Center considers for admission those multiple-handicapped children for whom there is no educational program within special educational facilities, children with multiple disabilities whose primary educational needs are not clearly determinable, and those children whose educational problems can be met only by more than one existing facility. When the project was initiated a survey was conducted to determine the number of multiple-handicapped children in New York City. As a result of the survey it was estimated that there are at least 3000 multiple-handicapped children in the City in need of educational and habilitative services.

Referrals are sent to the Coordinator of Clinical Services containing the following materials:

1. a psycho-social history of family and child,
2. a comprehensive psychological report based on examination done in the past year, signed by an approved psychologist,
3. a medical report describing the handicap in detail and including pertinent information derived from clinical procedures or tests to support the diagnosis; also reports of psychiatric or neurological examination, if available,
4. an educational report (if child was or is in school) describing the circumstances in class which require referral to a special setting, achievement levels in reading and mathematics, and a history in interpersonal and group relations.

The educational program at the Center encompasses a total approach to the child's needs based on a through knowledge of the child's history, abilities, disabilities, and potential. Grouping in this non-graded Center cuts across diagnostic lines and the curriculum is *highly individualized*, for each child requires a teaching prescription in addition to planned group activities that permit social participation. Use of multimedia material, special material, and equipment to produce multisensory reactions are other ways of reaching those children who are deprived in one or more sensory areas.

Licensed teachers trained in the areas of special education have been carefully selected for this staff and offer each other support through their understanding of specific handicapping conditions. They are ably assisted by a medical, clinical, and paraprofessional staff within the Center and, also, through the use of professional consultants and students internes from various universities and organizations. The attitudes that guide our teachers in their approach to the children are characterized by a willingness to experiment, to refrain from hasty judgement, to analyze each child, to see the worth of each individual, and to work toward individual maximum achievement.

A description of the student population over the course of two years was prepared by Alfred L. Scherzer, Medical Director of the CMHC. In order for the reader to better understand the nature and needs of the children attending the CMHC, his description and the summary of intake screening follow:

During the period April 1970 to June 1972 over 850 children were referred for admission to the Center for Multiple-Handicapped Children. Referral sources included Home Instruction Programs, special education classes for private special education programs under auspices of Public Law 4407, hospitals, health centers and clinics. Paper screening for eligibility on the basis of multiple handicaps and unavailability of suitable programs ultimately resulted in a reduction to 235 children who received full screening. The screening process included full medical, pediatric, and neurological evaluations at New York Hospital-Cornell University Medical Center, social service interviews, psychological assessment, speech, hearing and educational evaluations, and testing by an occupational and physical therapist. Qualifications of each applicant were carefully weighed by an interdisciplinary screening committee. Data concerning the 235 children who participated in the total screening process are included in the following tables. The 152 accepted children have been in the program for varying periods of time and are continually being re-evaluated.

In June of 1972 nine were graduated to other special education programs which could meet their special needs. In June of 1973 an additional twenty-nine children were able to be transferred to Special Education Programs and fifteen more children were graduated in June of 1974.

The 82 children who could not be accepted for this program have all received individualized recommendations concerning their educational and habilitative needs.

It should be kept in mind that the previous educational and socialization experience of this group of children was extremely varied. Most had experienced changes in school programs because of poor performance or limited acceptability. Many had no previous formal education due to multiplicity of handicaps. Almost all sought admission to the Center as a last resort for formal educational experience.

PROFILES OF TYPICAL STUDENTS

Case No. 1

A.A., a boy of 8 years of age, has congenital rubella syndrome. Features include bilateral hearing loss, eye abnormalities, fine motor deficits, and severe hyperactivity. An underlying severe emotional disturbance has shown some improvement with psychiatric treatment.

Previous school experience was in a hospital nursery program only. He was previously screened but could not be accepted by several special public school programs. Psychological testing indicated a dull-normal range of intelligence.

Case No. 2

B.B., is a seven year old boy who had severe respiratory distress at birth and showed marked delay in his milestones. He was early diagnosed as having cerebral palsy, spastic quadriplegia. He has a severe squint and expressive aphasia. Hearing is normal. Intelligence is on the educable retarded level. He is ambulatory with crutches. He has no previous formal schooling since he could not be retained in several public school programs because of his combined deficits.

Case No. 3

C.C., is a 12 year old boy with partial amputations of all extremities. Because of a chronic renal disease, the right kidney was removed at age 2 years. Due to a sense of rejection, he has developed severe emotional problems and has refused to wear artificial limbs. His intelligence is entirely within normal limits. No previous regular program of education had been established prior to his admission.

Case No. 4

D.D., is a 6 year old girl who was born with spina bifida (a congenital opening of the spine). She has a shunt for hydrocephalus and wears a urine collecting appliance on her abdomen following a urine diverting operation. There is partial paralysis of the legs. She has many perceptual-motor problems. Intelligence is in the borderline range. Previous education has been in a community preschool program for handicapped children.

Case No.5

E.E., is a 14 year old girl who developed meningitis at age 3. She was subsequently extremely hyperactive and difficult to control. A severe speech problem is present but she has normal hearing. She has seizures which are only partly controlled by medication. Intelligence is on the trainable level. She has been in a number of special school programs but has shown little response and has been on home instruction for two years.

SUMMARY OF INTAKE SCREENING (as of June 1972)

A. Total population, full screening: 235

1. Sex: Male 163 Female 72
2. age range: 5-16
3. Borough of residence: Manhattan 56, Bronx 66, Brooklyn 67, Queens 45, Richmond 1

SUMMARY OF INTAKE SCREENING

4. Acceptance status: Accepted 152, Not accepted 82, Deferred 1
5. Psychological status: Average/dull normal 65, Boarderline 38 Mentally retarded 132: (Educable 95, Trainable 37)
6. Diagnosis:

a.	Organic brain syndrome (OBS)	82
	with speech and hearing problems	23
	with emotional problems	9
	with visual deficit	4
	with visual speech problems	2
	with emotional, speech problems	3
		123
b.	Cerebral Palsy (CP)	29
	with speech and hearing problems	11
	with organic brain syndrome	4
		44
c.	Congenital rubella (CR)	25
d.	Congenital anomalies (CA) (includes meningomyelocele, hydrocephalus, amputee, cleft palate)	15
e.	Emotional disorder (ED)	9
	with visual deficit	1
	with speech and hearing problems	1
f.	Miscellaneous (M) (includes seizure disorder, Male Turner's Syndrome, Down's Syndrome, homocystinuria, dysgammaglobulinemia, cytomegalic inclusion disease, congenital icthysioform erythroderma, tuberous sclerosis, Treacher Collins Syndrome, neurofibromatosis	10
g.	Muscular Dystrophy (MD)	7

5. OBJECTIVES AND ACTIVITIES

The program objectives of the CMHC fall under four broad categories which may be described as follows: (1) to provide classroom instruction for multiple-handicapped children; (2) to provide training for professionals and others within and outside of the CMHC; (3) to foster programs of community relations and dissemination; and (4) to conduct research and evaluation programs.

The program at the CMHC is based on the philosophy that the education of a multiple-handicapped child requires a many faceted program derived from a thorough knowledge of the child's medical and family history, abilities, disabilities, and potential. Nongraded classes, diagnostic grouping, and individually prescribed instruction are some of the techniques that are employed to match the uniqueness of the child with an educational experience that will benefit him optimally. Planned group activities are utilized to develop the child as a social being. Special materials and audio-visual equipment are used to provide multisensory experiences for children whose limitations may require broader based sensory input.

Staff members are involved with the children in the following areas:

(1) The health needs of each child are given careful attention by the medical director and staff nurse.

(2) Interviews by social workers and guidance counselor provide initial and on-going case work services to children and parents.

(3) Psychological testing helps to define each child's emotional, social and educational needs.

(4) The speech therapists evaluate and diagnose speech and language problems, offering intensive individualized corrective programs.

(5) The occupational therapist helps children in activities of daily living and offers a program of perceptual training.

(6) The physical therapist carries out the prescriptions of the medical director and reinforces the physical therapy activities in the classrooms.

(7) Para-professionals are indispensible members of the staff acting in both the educational and clinical components.

(8) Each child at the Center for Multiple-Handicapped Children receives a carefully planned program of individual remediation and habilitation and each deaf child has many opportunities to work at stimulating tasks with FM auditory equipment. Every child is initially screened audiometrically by the school of Health Sciences (Hunter College) situated on the floor above the Center.

(9) The breakfast and lunch program is planned to provide meaningful group activities as well as individual prescriptive instruction.

One of the major goals of the CMHC is to help children develop to a level that will enable them to be transferred into special classes under the jurisdiction of the Division of Special Education and Pupil Personnel Services. The Center admitted the first group of children in January of 1971 and by June, 1972 the maximum student population of 128 children had been attained. By June, 1974 fifty three children had been able to meet the criteria of special education classes and had been transferred.

During the 1971-72 school year the Parent Association came into being. The Center is indeed fortunate to have the enthusiastic support of this Association. The leadership, guidance and cooperation of the Parent Association have been superb. They have developed a bridge to people in political life in the city, state, and federal government to benefit the education of their children and the children to follow them.

The Center has developed a good working relationship with colleges, universities, hospitals, the local school board and the East Harlem Community Corporation. Most of the para-professionals live in this community and the East Harlem Community Corporation performed the initial screening of applicants for the para-professional positions. Educational and habilatative programs at the Center were facilitated by the Center's development of an Individual Student Profile which is color-coded and contains all pertinent data on each child. Through this Profile individual prescriptive teaching for each child has been made possible. Teachers have been helped to develop appropriate educational prescriptions with the necessary methods, materials, techniques and equipment to implement these prescriptions within the classroom. The Center has provided practicum experience in terms of training and field work placement for both professional and para-professional personnel. During the 1971-72 school year the para-professional staff at the Center was enrolled in courses (lectures and practicum) offered by the School of Health Sciences (Hunter College). Para-professionals from other Bureaus of DSEPPS were invited by the Center to take part in these courses.

Medical research is being conducted effectively by the Medical Director and his staff. Medical internes and nurses in training are receiving invaluable training in the nature and needs of multiple handicapped children at the CMHC under the supervision of the Medical Director. During the first operational year (1971-72) the Center made every effort to disseminate information about its program. Visitors from the United States, Canada, South America and Europe visited the Center to observe the program. A brochure portraying the Center's activities was mailed nation-wide. Kinescopes of T.V. presentations were made and are available on a loan basis, and numerous newspaper articles and magazine articles were published.

In relating the involvement of the children with the community many memories come to mind, but one in particular stands out which illustrates their kindness and consideration towards their fellowman.

Last Thanksgiving, several teachers on the staff suggested that the children bring canned food from home to distribute to needy families in this community. They hoped, by so doing, that the children would better understand the concept of "giving" at Thanksgiving time.

The children brought a large quantity of canned food to the Center and spent time in decorating each can with colored paper. Some children could not bring food because of the needs of their own families so teachers established stores in classrooms and donated the food themselves. By so doing the children who could not bring their own food could visit the store and get food to contribute. At the Thanksgiving assembly the children, by class, gave the food to members of the East Harlem Community Corporation for distribution. The members of the Community Corporation were so struck by the children's gifts that they purchased turkeys to supplement the canned goods and distributed the food to a number of families in the community. It is the Center's intention to offer the children this meaningful opportunity of "giving" each year at Thanksgiving time and to likewise afford them the satisfaction of knowing they are helping their fellowman.

6. EVIDENCE OF EFFECTIVENESS

The evaluation conducted by Dr. Leonard Blackman and Dr. Leroy Clinton of Teachers College found that although a variety of evaluation objectives were pursued in this report on the first year's activities of the Center for Multiple-Handicapped Children, there is little question but that the "proof of the pudding" for any educational program is the growth of the children in it; and an analysis of the data relative to progress made by the children revealed that they had achieved significant gains on several academic skill and adaptive behavior variables as measured by scales constructed by the CMHC staff.

A. EVALUATION STRATEGY

Succinctly stated, the evaluation objectives, as presented by Drs. Blackman and Clinton, were as follows:

(1) review and evaluate the selection of standardized and other staff-constructed diagnostic instruments;

(2) review and evaluate the development of an appropriate core resource curriculum as well as those educational prescriptions that are based on diagnostic information about individual children;

(3) describe and assess the effectiveness of the educational and habilitative program for accelerating the growth of multiply-handicapped children;

(4) review and evaluate the efforts made by the Center staff to bring parents into the program;

(5) review and evaluate the dissemination of information to the immediate community and the number of referrals to and from public and non-public schools and community agencies;

(6) review records of (a) mailed information, (b) mass media and conference appearances made by professional staff, and (c) the number and quality

of published articles written by the professional staff;

(7) review number and type of paraprofessional roles designed for the Center's program as well as the degree of job satisfaction achieved by these individuals;

(8) review research in progress and completed on the medical, social, behavioral, and educational aspects of the total program for the multiply handicapped child;

(9) review the cooperation of universities and agencies in the adaptation of current research findings, new concepts, and techniques in developing new and better approaches to the education of the multiply handicapped child;

(10) review the resource pool of professional personnel trained by the Center staff to provide services for other multiply handicapped children;

(11) review the quality of the practicum experience provided for the professional trainees mentioned in objective 10 during their training period.

B. EVALUATION RESULTS:

In the interest of keeping this description of the evaluation results within reasonable limits, only the results of Objective 3 will be presented here.

Objective 3

The purpose of Objective 3 was to describe and assess the effectiveness of the educational and habilitative program for accelerating the growth of multiply handicapped children.

SUBJECTS: The target population of the evaluation was 83 multiply handicapped children (CA-10.7 years, range 4.0 to 17.0; IQ-72.0, range 30 to 113) whose disabilities included neurological impairment and disorders of behavior control. While 128 children were enrolled in the Center by the end of the 1971-72 school year, only the 83 children of the target population had been enrolled in the Center from the beginning of the school year, thus, only the progress of these children could be used to evaluate the efficiency of the CMHC program. There were 59 boys and 24 girls among the children in the target population for the evaluation.

METHODS AND PROCEDURES: Information was gathered at two points in the program (October and May) on the target group in the following areas: 1) intellectual, 2) reading, 3) numerical, 4) perceptual, 5) motor, 6) communication, and 7) adaptive behavior. Instruments used to obtain these data included the Leiter International, Bender Gestalt, Frostig, Wide Range Achievement Test, Motor Development Test, and a number of staff-constructed instruments (CMHC scales) covering adaptive behavior, communication skills, and achievement.

Descriptions and specimen sets are available in the measurement literature for all of the test battery with the exception of the CMHC scales.

STATISTICAL AND/OR QUALITATIVE ANALYSIS:

Pupil progress was assessed within a repeated measures design. Evaluation was based on growth of individual children in particular skills from checkpoint to checkpoint within the programs developed for each of them.

This method of evaluating the effectiveness of the program had to be chosen instead of the more typical and desirable experimental control group design. The possibility of obtaining a truly comparable control group which was trained outside of the Center or not trained at all was nil. Those children accepted for the Center's program are obviously different in important ways from those not accepted into the program.

RESULTS: t-tests for related groups were performed on the data in the following areas: 1) IQ; 2) number; 3) Time; 4) Writing; 5) Reading; 6) Socialization; 7) Emotional Tone; 8) Ego; 9) Violent Behavior; and 10) Attention. Because of the number of t-tests which were performed, a .004 level of significance was adapted for specific individual comparisons. This was done to reduce the possibility of spuriously "significant" results (Type 1 error) when a large number of comparisons are made.

Pupil performance in the areas of Number (CMHC Scale), Time (CMHC Scale), Reading (CMHC Scale), Socialization (CMHC Scale), and Ego (CMHC Scale) showed gains over the school year which were significant at the .001 level.

Positive gains were also observed in the areas of Attention (CMHC Scale), Withdrawal (CMHC Scale), Emotional Tone (CMHC Scale), and Anti-social Behavior (CMHC Scale); however, these gains did not meet the .004 level of requirement for significance. Center pupils showed positive gains in "Emotional Tone" and reductions in observed "Anti-social Behavior" at the .01 level; gains in "Attention" and reductions in "Withdrawal" were found at the .05 level.

The Sign Test was performed on test scores in the areas of Reading (WRAT), Arithmetic (WRAT), Motor Development, Bender Gestalt, and Geometric Figures (WPPSI). This type of analysis was utilized because there were fewer than ten pairs of "pre" and "post" scores available for these variables. Analysis of the data revealed no significant gain scores from October to May in five variables.

In summary, the CMHC program did produce significantly positive gains in children across some of the areas of academic skills and adaptive behavior measured by the CMHC Scales. Specifically, these were the areas of Number, Time, Reading, Socialization and Ego. In addition, non-significant positive gains were observed in the areas of Attention, Withdrawal, Emotional Tone, and Anti-social Behavior.

Statistically significant gains were not demonstrated on perceptual variables (Bender Gestalt and WPPSI Geometric Figures) or on academic skills variables as measured by the Wide Range Achievement Test. However, the lack of demonstrated significant gains may reflect the fact that the relatively few children who were tested on these variables (N-10) were a biased sample of the overall group.

A sample of CMHC children was selected to be filmed at two points of the school year, November and April. These children were selected to be representative of the age groups and degrees of disability found at the CMHC. Four children were selected in each of the following categories: (1) severe degree of disability, (2) moderate degree of disability and (3) mild degree of disability.

In addition, the children's ages fell into one of three ranges: 6-8 years, 9-11 years, and 12-14 years.

Both in November and April, each child was filmed individually while engaged for approximately four minutes in motor performance tasks. These tasks involved fine grasping (picking up toothpicks), gross grasping (picking up large, heavy wire gauge paper clips), winding string around a stick and turning pages in a book one at a time.

The sample of ten* pre and post films were shown to seven raters who had never seen the films before. These November and April Films were presented simultaneously for each child to the audience of raters who had instructions to select the film which portrayed the child's post-intervention performance. Eighty percent (56 of 70) of the rater's response correctly identified the pre and post films in the ten pairs of April and November films for each child. Against a null hypothesis that chance selection would result in 50% correct, these results are significant at the .00001 level based on the Binomial test.

The evaluators feel that the film results demonstrates that definite motor skill gains were made by CMHC pupils. The lack of a control group, however, precludes any definitive conclusions concerning the relative contributions of the program and maturity to the perceived gains.

Over all, the evaluation team feels that compelling evidence exists that the programs of the CMHC did produce significant gains in some of the academic, life skills, and perceptual-motor skills of the children. The conclusions must be considered somewhat indetermininate, however, because of the absence of a control group that would have permitted the evaluation of maturational or practice effects. As indicated earlier, it was not possible to obtain an equated control group. However, the extremely slow and frequently undetectable rates of growth typical of multiply handicapped children receiving programs inappropriate to their disabilities or receiving no programs at all, makes the significant findings reported here both provocative and encouraging.

SUMMARY OF EVALUATION AND RECOMMENDATIONS:

Gains were achieved by the children in the face of some rather negative perceptions by the teachers at the beginning of the school year concerning: (1) the relevance of diagnostic data collected by the Center's professional staff to the instructional process: (2) the rate of progress being made in curriculum development in arithmetic, language arts, adaptive behavior, perceptual skills, and motor skills; (3) the quality of in-service training and supervisory help in curriculum development; and (4) the helpfulness of audio-visual personnel and facilities. Encouragingly, in the main these perceptions brightened considerably as the school year progressed.

The role played by ancillary professional services in furthering teachers' goals was explored. Generally, the psychologists, occupational therapists, and physical therapists received the most favorable teacher response.

Efforts made to increase the involvement of parents in the program must be considered an unqualified success. The parents overridingly proclaimed their satisfaction with both the quantity and quality of contacts that they had with the professional staff of the Center.

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*two of the original 12 pupils were filmed only once because they were absent.

They are almost unanimously pleased with the program being offered their children and perceive that their children are being significantly benefitted by it.

The paraprofessional program has also been extremely successful. The paraprofessionals have judged their roles to be meaningful and their activities useful. This finding was confirmed and reinforced by the teachers who were, with only one exception, strongly positive about the paraprofessionals assigned to them.

A heavy dissemination effort at both local and national levels was made by the administrators of the program. Much of this dissemination was devoted to introducing the program to both the professional community and the public at large. It is to be expected that future efforts will turn to more substantive contributions to the theoretical and empirical literature in this field.

University-initiated research and development programs have been in progress at the Center all during the school year. These research programs have also contributed significantly to the service programs of the Center. As the Center consolidates its programs and activities in the coming year or two, research and development programs should begin to be generated by the Center staff with, hopefully, continued interest and involvement by the universities. Both related to and independent from research and development programs, the Center has been involved in the training of professional personnel concerned with the education and habilitation of multiple handicapped children.

The children did make substantial progress and it was demonstrated that the education of multiple-handicapped children in classrooms is both feasible and desirable. Plans should go forward to expand the number of facilities available to these children. Hopefully, experience gained here can forestall problems in the construction and development of other such programs. The CMHC can also be looked to as a model for establishing programs for parent and community involvement. Lessons have been learned here that can be useful not only for other Centers in the future but for the full range of public education.

Finally, in its first year of operation, the CMHC has struggled through a variety of building, financial, and pedagogical problems and, to its credit, has emerged with a program that is working in terms of children's progress and parent involvement and improving in terms of the perceptions of its own professional staff. The recommendation that this program should be continued and strengthened is made without reservation.

7. COSTS:

The planning Grant Award extended, originally, from January 17, 1969 to June 30, 1969. It was then extended through July 31, 1969. The amount of funding approved was $49,714.00.

Two grants were awarded for the period August 1, 1969 through June 30, 1970- the one for $290,000, the other for $912,700. The grant of $290,000 was used for building remodeling purposes as well as $55,000 from the grant of $912,700. Thus, $345,000 was expended for demolition and renovation purposes.

This first year grant of $912,700 was extended from June 30, 1970 through October 31, 1970 and this extension was followed by a second extension which carried the CMHC through January 16, 1971, followed by a deobligation of $258,300.

The next grant award, for fully operational costs, was for $1,150, 169 for the period January 17, 1971 through January 16, 1972. This grant was followed by a continuation grant of $408,921 for the period January 17, 1972 through June 30, 1972.

On July 1, 1972 tax-levy funds were made available for the continuation of the CMHC through the Board of Education of the City of New York for FY 1972-1973. At the present time a budget is being submitted for FY 1975-76 for the establishment of a second Center for Multiple-Handicapped Children in New York City under tax-levy funds.

Operationally, the cost per-pupil, if based on a population of 128 children the maximum possible at one time at the CMHC, is approximately $8,000. If based on the fact that approximately 143 children are educated at the CMHC each year due to transfers to special education classes, the cost per-pupil is $7,278.

8. PROJECTIONS:

The CMHC has obtained a Grant Award for the period July 1, 1974 through June 30, 1975 under the Vocational Education Act - 1968 Amendment to establish an "Occupational Skills Training Program for Multiple-Handicapped Young Adults".

This program is designed to develop and equip occupational training shops at the CMHC incorporating the following areas:

1. Production Skills
2. Packaging and Mail Room Skills
3. Distributive, Business and Clerical Skills

The grant provides occupational skills training to the young adults attending the Center as well as job development and follow-up. It will provide individual and specialized instructional techniques to maximize potential for transition into gainful employment in semi-competitive areas and sheltered workshops, and it will serve as a prototype and evaluation source to expand occupational skills training for the multiple handicapped.

The three occupational skills training areas will be structured in training units modified to meet the needs of this special population. Individualized instruction will be provided in small assembly, mail room operation, sign making, duplication skills, distributive, business and clerical operations. Achievement data in each of these educational program areas will be collected and Individual profile instruments will be developed to evaluate educational achievement and to predict, in some measure, whether or not success may be expected in placing our multiple-handicapped young adults in semi-competitive work or in a sheltered workshop program.

A second Grant Award has been obtained by the CMHC under Selection 306 of Title III, ESEA of 1965 for the period July 1, 1974 through June 30, 1975 as a Developer-Demonstration Project.

We view the role of the CMHC as a National Demonstration Site in two ways. First, many additional visitors will come to the Center for an on-site observation of the program. We intend to develop a library of informational material which will be accessible to them. Material from the library will be distributed free of charge or on a loan basis. Secondary, informational material (educational, clinical, medical, parental, community) will be mailed to school systems or universities requesting this information.

One of the prime objectives of the CMHC is to promote replication of Centers for Multiple-Handicapped Children throughout the city, state and nation. In order to encourage other localities to replicate the Center's program, printed and audio-visual material will be professionally prepared and additional supplies and equipment required for educational, clinical and medical use in a national demonstration site will be purchased. Staff members in each of the Center's disciplines have been contributing papers for dissemination purposes and this material will be prepared for printing.

An internship program has been established whereby teachers, medical interns and nurses, psychologists, social workers, guidance counselors and paraprofessionals have received and are continuing to receive training in these different fields at the CMHC. The logistics of this program will be expanded to offer these same services to potential adopters.

The primary projection, however, for 1975-1976 is the establishment of a second CMHC. Budget considerations, architectural drawings, cost-analysis figures, bus routes, staff recruitment, and the establishment of a list of children eligible for admission are all factors that have been considered, decided on, and made ready for implementation.

This report, hopefully, will provide insights for those readers who may be motivated to establish Centers for Multiple-Handicapped Children in their cities throughout the United States. An interesting fact is that the purely educational and habilitative aspects of the program evolved naturally and were, and are, a source of happiness to all the members of the staff. Problems in development of the program were minimal. The main source of problems came from unexpected occurrences. For one thing, the physical environment of the Center had been, up until a year ago, a source of continuing frustration for children and staff. No amount of fixing or patching solved the heating or air conditioning problems. It is to the credit of the children and staff that their morale remained high under very frustrating physical environmental conditions.

Another source of deep concern was introduced on March 9, 1972 when the Center was advised that it would not be eligible for tax-levy funds to continue operations during fiscal year 1972-1973. This news hit the staff and parents with a stunning effect. But, again, instead of giving in to pessimism everyone worked together as a team in a positive manner to have the CMHC placed back in the budget without any loss of services, and this was accomplished.

Once again, to their credit, not one member of the entire staff asked for a transfer during those dark days even though many had family obligations to meet. If anything, the Center came out of its fight for survival much more unified and purposeful than it had been before it entered that struggle.

The "idea" for the CMHC keeps lending itself to many more educational possibilities for the handicapped child and young adult with the passage of time and ESEA, Title III and the Board of Education of the City of New York must be not only thanked but congratulated for making it all possible and for offering the tools to make the idea become a fruitful reality.

During January, 1973 the Center for Multiple-Handicapped CHildren was nominated by New York State, together with approximately 125 ESEA, Title III projects nation-wide, to be validated under the "Identification/Validation/Dissemination (IVD)" program being sponsored by the United States Office of Education in cooperation with the states.

As a result of this nomination for validation an out-of-state team evaluated the Center during February, 1973, to determine whether the CMHC met the criteria of innovativeness, exportability, significant achievement or improvement, and cost-effectiveness. The Center successfully passed this evaluation and was declared a National Demonstration Site and granted an Educational Pacesetter award with the intent of making possible the establishment of other Centers for Multiple-Handicapped Children throughout the nation by means of a concerted dissemination of information program.

During the past few years many things have been learned and most of what was learned was taught by the children. Somehow their light always shines through. Over and above all else there is always the child - what he is, what he will become.

THE ROLE OF THE SPECIAL EDUCATION COORDINATOR

Allan Schulps
Coordinator

In any new facility, particularly one that is specifically charged with being innovative and experimental, defining one's role is challenging, puzzling, and subject to constant change until an integration of essential functions and components is achieved. Essential components include the personality, philosophy, and goals of the coordinator, the latitude permitted by immediate and higher-level administration (in terms of permissiveness, delegated areas of responsibility, and budgetary aid), the physical plant as it affects children and staff, the degree of cooperation that evolves among all staff members, and the nature of the pupil population. It will take awhile, perhaps as much as two or more years from the initial phase, before these elements have developed and emerged into a pattern that is clear enough to enable one to define the role of special education coordinator in a sensible and comprehensive manner. Of course, the term "special education coordinator" sheds little light on the actual functions of the position since it simply connotes that special education is involved, along with a coordinating activity that is intrinsic to nearly all leadership roles. It is our intention, therefore, to analyze and clarify the operative elements of the role as it developed over the first few years of the establishment of the Center for Multiple-Handicapped Children. We may divide these functions of the coordinator into three general, but interrelated categories. The first deals with people. Our focus here is concerned with roles, and interpersonal relations. Second, the program. Emphasis here relates to what we are attempting to achieve and how we go about achieving it. Third, the facility. Where do we operate and what things do we need to function? All three categories will be discussed in the framework of their relationship to the role of the special education coordinator.

1. PEOPLE

The Children:

We should never forget that the facility exists to serve the children. Therefore, we accord the children's safety, health, comfort, education and happiness the highest priority. The special education coordinator must be aware of all the elements involved in helping to achieve the optimum benefits in every one of these areas. Where, when, what are the danger points? Is there sufficient supervision for group activities? Are individual children being given greater freedom than they can manage at certain times? Are we too overprotective? Is there an atmosphere of care, warmth, and joy? Are we reaching the minds of the children in a way that promotes academic growth, social maturity and physical and mental health? Do the children care for each other? Are they given opportunities to help each other? Does the entire staff reflect this attitude of care for the children? Do classroom teachers and their assistants see all the children in the program as worthy of their consideration, in addition to the children specifically assigned to them? Do all members of the staff expand their roles to assist children as needed?

Does the special education coordinator behave in an exemplary way concerning all of these areas? Is the coordinator really interested in knowing the children in every aspect of their behavior - at home, the classroom, lunchroom, toilet, bus? This series of (what we hope are) rhetorical questions provides clues to a desirable relationship between and among the coordinator, the staff, and the children.

The Parents:

If the program exists for the children, then the parents, who are closest to the children, must receive our welcome and attention. The mutual advantages of a cooperative relationship are so obvious that the institution of an open-door policy, frequent personal contact, and an active Parents Association are absolutely imperative for maximum progress with the children. The coordinator, along with other staff members, views parents as partners, emphathizes with them admires them for their patience and fortitude (how else should staff members feel toward a parent after they have experienced lifting a heavy boy with muscular dystrophy or spending a lengthy block of time taking off and putting on the two full leg braces of another child)? and eagerly seeks their advice and help in understanding and assisting their children. One should be humble and grateful in the presence of these parents.

The Teachers:

The coordinator assumes that any "special educators" ought to have special qualities of dedication to their children. Based on an open trust, the coordinator refrains from interfering with the teacher who is experimenting, exploring, and evaluating both the children and whatever makes the children learn. The teacher's own personality and preferred style are given free rein just so long as they are productive and operate within the boundaries of good mental hygiene. The coordinator offers personal support to the teacher in crisis situations, curricular activities, interdisciplinary relations and any area of operation at the Center. Educational staff selection, an important role of the coordinator, is aimed at achieving a balanced, diversified staff in terms of training in areas of exceptionality, amount of experience, and sex. Teacher training, both in-service and through university courses is encouraged. Demonstration lessons, lectures, material displays, and attendance at professional conferences are important ongoing activities. In catering to the total needs of the child, teachers seek help from all available personnel and share their own strengths with others. The duties of the special education coordinator are broad enough to require that many tasks be delegated to responsible teacher leaders. At the Center one such person, designated as teacher-coordinator, assumes many duties related to such diverse items as curriculum scheduling and lunchroom management. Other teachers share assignments as committee members or leaders. Without this shared responsibility, the special education coordinator would either be overwhelmed or ineffective.

Paraprofessionals:

The role of the paraprofessional at the Center is vital to the successful attainment of its goals. A keen awareness of this fact prompts the coordinator to be sensitive and understanding in the utilization of the many strength and talents possessed by these members of the staff.

By and large they are people drawn from the immediate community and they have been of inestimable help in interpreting (literally, at times, in Spanish) the role of the Center as it operates to assist children.

Each of the sixteen classrooms with a maximum of eight children is staffed with a teacher and paraprofessional. One of the true joys of the coordinator is to witness the display of a harmonious working relationship and camaraderie that characterizes so many of these paired teams. Primary duties of the paraprofessionals involve assisting the children in activities of daily living and rendering a tutorial role within the classroom under teacher guidance. Bilingual education for the children is often enhanced by many of the English-Spanish speaking personnel and much assistance is also rendered in working with parents and visitors who have difficulty with English. Paraprofessional growth through post secondary course work and in-service training is encouraged. The warmth and affection of these staff members toward the children is an element of surmounting importance in mutual growth and development. That affection is nurtured by the close physical contact that is so much a part of the daily routine, by the responsive, friendly children and, hopefully, by the encouraging atmosphere at the Center.

Student Teachers

Within a month of the opening of the Center, student teachers were on the scene to help and to be helped. Fortunately, New York City has many universities where special education courses are offered, and since the Center has a population which manifests nearly all the diagnostic entities requiring special education, a relatively easy recruitment of student teachers has prevailed. Students have been assigned here from Columbia University, Fordham University, Pratt Institute, and New York University. The length of stay has ranged from several weeks to a full school year. The coordinator encourages this mutually rewarding aspects of the program by acting as liaison with the universities and through initial orientation of the student teachers at the Center. It is hoped that the work of the Center will radiate outward as these student teachers take their places in various special education programs. It is also our feeling that the warm and open reception accorded these students helps them to respond in kind. The record is so replete with two-way satisfaction that we view this entire relationship as one of the most satisfying in bringing additional benefits to our children at the Center and to future,unknown beneficiaries.

Clinical Personnel

The practice of interdisciplinary teamwork is one of the principles upon which the Center has based its hope for a successful program. To have "under one roof" a clinical coordinator, medical director, staff nurse, physical therapist, occupational therapist, two psychologists, two social workers, a guidance counselor, and a full pedagogical staff, including three speech improvement teachers is to come close to the dream that so many educational practitioners have envisioned in providing supportive services for meeting the complex needs of severely handicapped children. Yet, the mere presence of ingredients, good and varied as they may be, does not make a successful end product unless the blend is correctly proportioned, mixed, and tempered. A coordinator must assist im making the mix work so that the end product-the happy child functioning at maximum potential-is realized. Here again, definition and redefinition of roles has been ongoing since the Center opened. By now, one senses so much more comfort, relaxation, and confidence in contrast with the earliest days. The recipe would seem to be working and one measure of its effectiveness is the large number of children who have been transferred to less sheltered, closer to mainstream special education settings.

Office Staff

A group of dedicated, hard working people not only help with what seems at times to be a mountain of paper work, but are in a real sense "front-line" personnel in responding to the numerous telephone calls and visitors who arrive with and without appointments. The coordinator works closely with office personnel in allaying the fears of anxious parents and children over possible illnesses, bus delays and a host of other problems. The office staff is another crucial element in the smooth functioning of the Center.

Other Personnel

The expression "other personnel" in no way diminishes the important role of each person and the coordinator must recognize this fact or face unhappy consequences. The cook and assistant cook must see their own importance in another vital aspect of the program which includes a breakfast and luncheon for each child. We have been fortunate in this regard and the coordinator has had the great pleasure of seeing the loving care that makes routine fare both palatable and happily received.

The security guard and custodial help perform important functions that obviously relate to the welfare of the children and the entire staff.

The bus drivers and attendants are vitally important in many ways. Their willingness to go beyond their general duties is deeply appreciated. The coordinator has always maintained a very close relationship with these people because our children, who are all bussed and come from all over the city, will be educationally deprived if they fail to be picked up by the bus, if they arrive in such condition as to be unreachable and unteachable, or if they reach home in such a state that they or their parents are reluctant to use the bus. The obvious importance of the bus situation requires that bus personnel feel and appreciate their role in the furtherance of the education of the children. The coordinator tries to foster this sense of warmth and responsibility of bus personnel toward their charges.

Visitors

Since its inception, the Center has not only maintained an "open door" policy in regard to visitors, but has actively sought to invite all who are interested in viewing the Center. The entire staff is aware of this philosophy and cooperates to the fullest in maintaining regular routines regardless of the presence of visitors. The children have adapted well to the situation, too, by either disregarding strangers or welcoming them warmly. In general, there has been a very small amount of interruption considering the very large number of visitors. The coordinator feels that a careful and accurate interpretation of the program is extremely important and is the due of all who are willing to visit. Therefore, the coordinator frequently participates in arranging and conducting tours of the facility.

Friends

One day in May we moved our school population some three blocks west, right into Central Park for a picnic. A trail of over 200 people, wheelchair riders, fast walkers and slow walkers accompanied by a police escort of perhaps ten men to handle traffic, a joyful group moved into a section of the park where alerted Park attendants had reserved a spacious area. The staff, parents and friends, all had contributed or prepared food and equipment so that every class had its own grill for a cook-out in addition to a central community table of goodies for every-one. A joint operation of many helpers within the Center and the community had made possible one of the most beautiful days in the life of many people.

One day a child with severely impaired vision stumbles and loses his glasses while his class is walking a half block away from the Center. The very expensive, special glasses have disappeared and it must be assumed that they fell down the water and mud filled sewer on the corner. The Bureau of Electricity and Sewer Maintenance is called. A dredging crew comes and the class watches while pails of water are lifted out of the sewer and the glasses are sought. The class returns to the Center and the men keep working. A half-hour later, a triumphant crewman runs into the Center holding up the glasses. The child screams with delight. It's good to have friends.

At Thanksgiving, a special assembly is held. Children from the Center bring food to be turned over to our neighbors, the East Harlem Community Council, for distribution to poor people in the community. Deeply touched, the Council adds to the store of food and a very sizable allotment is distributed.

One need not sermonize on the meaning of friendship to realize that the complex needs of our population are better met when help comes from many sources. Whether the source is the parents. our advisory committee, high ranking political figures, mass media personalities, Board of Education personnel from headquarters or the community school district, volunteers, who perform at assemblies, neighbors such as the East Harlem Community Council, Hunter College Institute of Health Sciences,or Manpower Development Corporation, and any of a host of other people, the Center accepts with gratitude their great kindness. Again, the coordinator does all possible to promote the notion that reaching out for friends makes life richer for all.

Administration

Administrative functions at the Center are characterized by a full realization that service to children governs our actions and that those who work with the children deserve support, encouragement, trust, and the unleashing of their potential to benefit the children. This attitude is held by the Director of the Center and there is little question that its effect on the other administrators and all personnel at the Center is responsible for much that has been achieved. While there are many facets to administrative duties and responsibilities, the behavior attendant to the above plus the support and financial backing of high ranking personnel at the Division of Special Education and Pupil Personnel Services of the Board of Education are major factors in bringing a worthwhile program to the children.

11. The Program

For our purposes here, we shall only be able to touch upon some of the highlights of the program, but we hope to reveal its most salient features. Again, one must consider the context under which we were operating; that is, as a new facility, experimenting, evaluating, defining, redefining, amd learning, hopefully, succeeding in achieving the desired type and pace of growth and development in the children. The program will be presented under the following headings: Grouping, curricular practices, supportive services, and special features.

Grouping

While grouping relates to a number of purposes, the principle question to be answered is, "which children go into which classes?" The answer is based upon a number of factors whose main elements revolve about the nature of the population, the background and strengths of the pedagogical staff, and optimum utilization of the physical plant in terms of classroom space and other aspects. Let us consider these elements.

The general nature of the population is multiple-handicapped with ages ranging from five through seventeen, but the actual details of the kind and degree of deficits as well as the numbers of children with their associated disabilities had to follow the admission of the children to the program. Nevertheless, as a modus operandi, tentative guidelines were established for class groupings. Basically, guidelines involve functional or potential social and academic achievement levels, and the age of the child. With few exceptions, general diagnostic labels were not to be used for grouping.

Since teacher selection had been made with a view toward a good mixture of strengths in various areas of exceptionality or age levels, whenever groupings revealed certain central tendencies among the maximum number of eight children, the teacher who might be most comfortable with the group was chosen to lead it. Central tendencies in grouping seemed to evolve randomly because of the large number of variables compared with the small number of children in each class. Thus, some classes did contain a high proportion of severely physically handicapped children, while others were characterized by severe functional retardation, emotional disturbance or neurological impairment. All teachers were aware that their own background and training would be utilized in the best possible fashion, but would not be considered as a factor in eliminating a child from a group where the general guidelines indicated that group as the best placement. Thus, if a blind child were overaged for the class of the teacher trained to work with the blind, the teacher in whose class the child was actually placed and whose major training might have been in the area of mental retardation could seek assistance and guidance from the teacher with expertise in working with blind children. The one area where a conscious effort was made to group children by a primary diagnosis involved deafness, a move explained as follows:

Because it had been decided to equip three classrooms with sound magnification units, it was thought best to use deafness as a common denominator for an early childhood, a middle and an older group of children. However, this grouping was not rigid and it did turn out that the very large number of children at the Center with hearing losses required that many be placed in other classes as well. One sees here how the nature of the physical plant (i.e. sound magnification equipment) has effected grouping practices. More obviously, the size of the rooms dictates the maximum number of children in each class and at the Center classrooms were designed to accommodate eight confortably.

We believe that our system of grouping has worked well. Whenever situations have arisen where teachers, clinicians, parents, or children have been unhappy with a particular placement, a meeting of an interdisciplinary team has helped work out the problem, effecting an interclass transfer as needed. The coordinator participates in the team effort to effect sensible, viable, compatible groupings.

Curriculum

We consider our curriculum to consist of the whole range of planned experiences that our children encounter at the Center. In general, there have been two formal experimental curricula, each involving four classes, and a rather eclectic approach to curriculum in the other eight classes.

The formal curricula have involved the Taxonomy of Instructional Treatments, a model created and popularized by Dr. Abraham Tannenbaum of Teachers College, Columbia University and Social Learnings Curriculum, the basic work of Dr. Herbert Goldstein of Yeshiva University. It is not our intention to offer a detailed account of these models, but a general statement about each is in order.

Taxonomic Teaching, a classification and numeration system, is very much in the popular mode of individualized instructional designs. Its focus is on specific teaching approaches with given children. Installation of a taxonomy at the Center was fraught with difficulty because of the complex needs of the children, but a fine team of consultants and student interns from Teachers College worked closely with our staff to help individual children capitalize on their known abilities before employing strategies to remediate specific deficits.

The social learning curriculum provides a content framework for teacher use and focusses on those areas of practical life skills that are crucial to social emotional growth. While theoretically designed for an educable retarded population, one easily recognizes the applicability of this curriculum to children of a much wider range of intelligence when social quotients and age factors are considered. This well-organized body of material has provided a fine base upon which some of our teachers have built both individual and group learnings.

Other approaches to curriculum have involved a variety of programed materials and systems, chosen with the hope of remediating, developing or reinforcing the percepts, concepts and skills of each child.

Such programs as offered by Teaching Resources, Peabody, Frostig, Stern, Cuisenaire, Michigan Language, Rebus, Distar, and many others designed for exceptional children have proven useful to varying degrees. The proximity of a regional and research section of the Special Education Instructional Materials Center has made available a number of materials and programs for experimentation.

The vast array of programs that are available cannot provide, by themselves, easy solutions to children with gross disorders or subtle combinations of deficits. It has been our experience that teacher enthusiasm, creativity, experimentation, patience and dedication, coupled with support services as needed, are more important than any curricular system designed for a theoretical population. The coordinator, ably assisted by many others, has worked to facilitate the acquisition or reinforcement of attitudes that treat the curriculum as so much carefully selected raw material to be patterned, cut, and tailored to meet each child's assessed needs.

In assessing each child's needs, the assistance of the psychologists was sought in constructing an "educational profile". This instrument provides a very comprehensive overview of a child's background, strengths and weaknesses. It is most useful as a diagnostic tool for the creation of prescriptions for all the disciplines to follow. Thus, the currently popular "diagnostic-prescriptive" approach has been used with some degree of success at the Center.

Where individual children have shown abilities which should be expanded or heightened, such measures as the use of pupil tutors or periodic class intervisitation to accommodate the pupil's area of strength are employed. Thus, if a child's high reading level is far beyond the rest of the class, the child spends his reading period in a class where the reading level offers an opportunity for greater gains.

In addition to the regular classroom teachers who concentrate on the more standard content of the curriculum, (3R's etc.), four specialists focus their attention on areas that have enriched the program immensely. These teachers specialize in multisensory media aids, puppetry, motor training and music. The value of their contribution is measured by the enthusiastic participation of the vast majority of the children. At various times, trained specialists have sought employment at the Center in such areas as music therapy, dance therapy, and art therapy. We do believe that these people might have rendered a fine service to the children, but it is apparent that budgetary considerations impose limitations on our ability to fully utilize every worthwhile activity.

Supportive Service

The special education coordinator works closely with the coordinator of clinical services and the medical director to activate maximum cooperation between the teachers and paraprofessionals and the personnel who offer supportive services in speech, physical and occupational therapy psychology, social work or counseling, and medical practices.

To the degree that children need supportive service on a regular or emergent basis, the participation of the child in classroom activities is curtailed. One might become concerned that a given child might be negatively affected by too frequent utilization of so many services, but such adverse results do not seem to have occurred. Actually, the positive interaction between teachers and supportive personnel has been very pronounced, with teachers often referring children for assistance and then following up suggestions for classroom activities that might be helpful. Formal and informal conferencing affords opportunities for ongoing evaluation of gains and losses. Clinical intervention for dealing with crises, remediation in areas of deficit, parental contact or involvement, and general suggestions help the classroom teachers and paraprofessionals deal more effectively with the children.

Valuable roles are played by the clinical personnel in the intake and transfer procedures. Screening for admission to the Center is an interdisciplinary function which enables all involved personnel to render tentative judgment about a child's present status and potential. The quantity and quality of gathered information assists the staff and the child in effecting a smooth admission to the Center or makes possible the suggestion of alternatives if the child is not admitted to the Center. When children have profited sufficiently by the Center's program to warrant consideration for possible transfer to a less sheltered facility, once again, a multidisciplinary review and decision with parental acquiescience is employed. The special education coordinator is involved in both intake and transfer procedures assisting in arriving at decisions and in the logistics required to gather information. In regard to transfer, it should be emphasized that the movement of children closer to the mainstream via the many fine special education programs in regular schools is a basic feature of the program.

Special Features

A varied population requires a varied program if we are to offer opportunities for every child to participate, enjoy or be engaged in worthwhile activities. We have already noted the contribution of a fine group of special teachers in the areas of puppetry, music, motor training and media. In addition to regular scheduled periods with different classes, these personnel assist in the creation of assembly programs which are calculated to inform and divert the children. All assembly programs involve the children in some respect; perhaps, in a rotating color guard, as members of the Center chorus, or as participants in a prepared program. Many of the assembly programs have included guest performers, both amateur and professionals, as well as a host of visitors from public and private agencies who entertain, demonstrate or lecture.

Trips are another feature offering educational and recreational aspects. Short neighborhood trips to a nearby park, stores, shops and a variety of community facilities are particularly encouraged. The logistics of such trips are simple and require relatively little preplanning. In good weather many classes will leave for periods ranging from ten minutes to two hours with distance and place of visit linked to the physical and intellectual levels of the children.

One basic requirement for these short trips is adequate adult supervision with a minimum number of two adults, or more, if the nature of the class suggests it. While longer trips requiring transportation facilities may be worthwhile, and, indeed, are undertaken, their number is very limited. One important reason for the limitation is the fact that many of the children have lengthy travel time between home and the Center and the fatigue may affect the physically involved children and others adversely. Nevertheless, museums, zoos, and engaging shows are visited by interested groups.

The summer vacation finds many of the children at home in a state of relative isolation and loneliness unless parental initiative and knowledge has enabled the children to participate in some group activity. The clinical coordinator along with the social workers and guidance counselor help to carryout the Center's strongly felt responsibility for making available a worthwhile summer program for any child whose parent consents.

In a variety of ways an attempt is made to engender among the children a feeling of the highest degree of dignity and self-worth. This is only possible if the staff, itself, has such a feeling and communicates it to the children. In this regard, we are especially concerned about children who are ready to graduate or be transferred. For graduates great concern exists to provide an adequate program of career training. Close articulation has been made with Board of Education personnel involved with career training and each student is reviewed for followup in occupational training. At the Center preoccupational aspects are woven into the curriculum at many levels and recent plans will help establish a regular program of occupational skills training.

It is our feeling that an ungraded system of class organization has freed both children and staff from the psychological fetters that bind the minds of so many children and adults in mainstream education. The diminution of heavy competition for marks and promotion has permitted many of the children to realize that they can make contributions of distinction for themselves without being subjected to odious comparison with the efforts of less disabled persons. Reports to parents follow along similar lines depicting in narrative style the child's degree of progress from one period to the next in the context of individual growth.

In all the above special features, the special education coordinator plays a role as consultant, adviser, participant, planner, and supporter.

111. The Facility

The term "facility" is used here in the sense of material things required to conduct all aspects of the program. It would, therefore, include such items as educational materials, furniture, equipment, and the basic physical plant. It is our purpose to discuss these items briefly as they impinge upon the total program and the work of the special education coordinator.

A committee of teachers under the general guidance of the special education coordinator was given the responsibility of ordering the educational materials, supplies, equipment and some of the furniture prior to the actual arrival of the children at the Center. The committee had to make some educated guesses about the appropriateness of their choices for this special population.

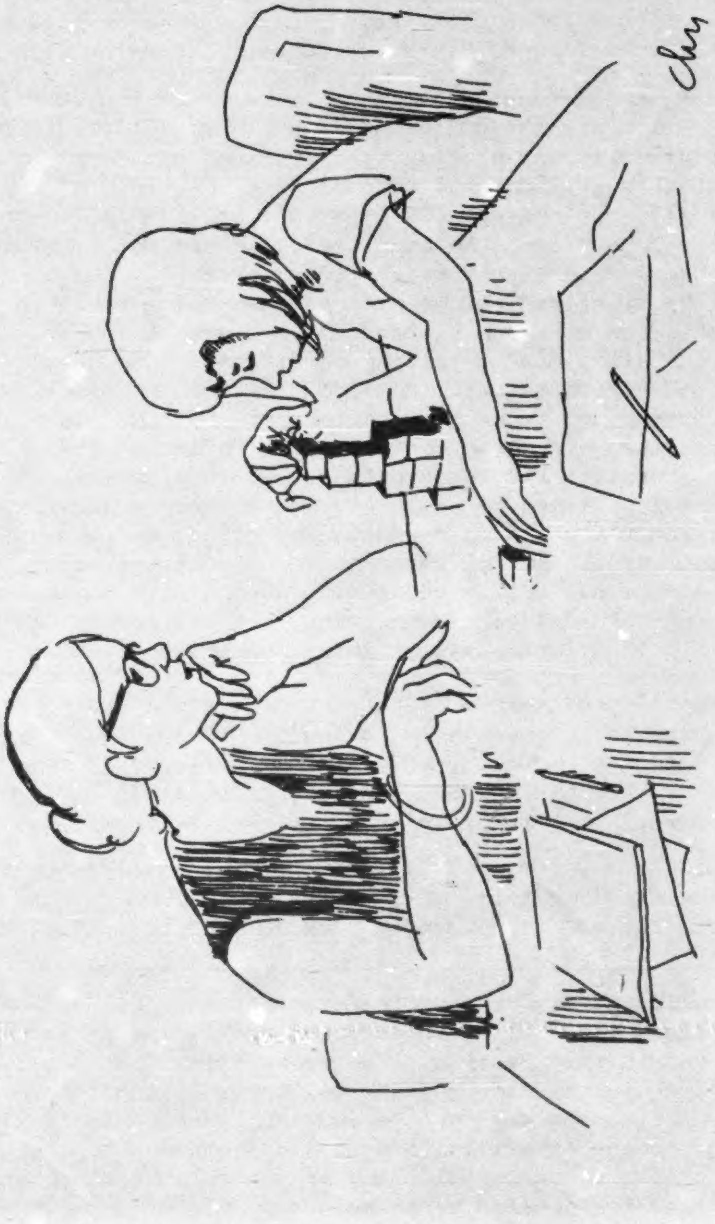
The committee's own education was a product of each individual's background and training, but was enhanced by visits to perhaps a dozen special education facilities, public and private, to get ideas and suggestions. The result was a very heavy concentration on audio-visual and programmed materials. An optimistic view of the population's reading level resulted in an oversupply of textbooks from about grade four to grade eight (the highest) reading levels. However, their selection of audio-visual and programed materials proved to be advantageous. Once experience had been gained and the program was well established, each teacher assumed responsibility for his or her own class materials. However, there are periodic demonstrations of new materials and frequent teacher exchange over successful experiences with both teacher-made and commercial products. In general, the use of good, sturdy school furniture has worked well.

We have learned some lessons about a few aspects of the physical plant and its specific design for the multi-handicapped population. The use of railings to assist children with ambulation problems has enabled many to negotiate corridors successfully. Careful attention to the width of doorways for wheelchair or wide gait passage is important as, indeed, is the elimination of all architectural barriers. An experimental design of a triple classroom to be separated by movable furniture proved unworkable. The theory of open space and its benefits did not operate successfully with this population because the children were too distracted by their neighbors. It was necessary to install floor to ceiling partitions. Nor has the use of carpeting proved efficacious in the five classrooms where it was installed. The static electricity proved hard to control, but the cleanliness and maintenance factors were even more distressing. Toileting and the management of this whole aspect of the children's daily needs as part of the more general area of activities of daily living has been a very important factor in keeping the children comfortable, clean, and happy. In this regard, adequate provision for space and proper distribution of toileting facilities would be helpful. Needless to say, trained, sensitive personnel are required for this delicate management, but all members of the staff should feel an obligation to assist in any emergent situation.

Our "multipurpose room" serves as cafeteria, assembly room, and gymnasium. If separate space is not available for each purpose, then careful attention should be paid to the use of sturdy, lightweight, easily movable furniture. Our multipurpose room has worked out well, in general, but constant attention to cleanliness and furniture movement is required.

Adequate provision for bus arrival and departure in close proximity to school entrances is important. Our entire population is bussed, many from long distances and very careful planning for reception and departure is required.

Again, the special education coordinator plays a role in all aspects of the facility since the child's educational program is affected by every factor mentioned in this section. The role varies from general surveillance, to specific attention to safety features, to gathering information from staff members as to problems in care and maintenance, to facilitating the acquisition of proper materials, supplies and equipment. As noted earlier, the only way the role can be fulfilled is through the sharing and delegation of responsibility to selected personnel.



THE SELECTION, INTAKE SCREENING, AND EVALUATION OF MULTIPLE-HANDICAPPED CHILDREN

Gerald Ehrlich

The Center for Multiple-Handicapped Children, located in East Harlem, and under the jurisdiction of the New York City Board of Education is an educational setting offering an optimal educational program to multiple-handicapped children through an integrated and coordinated multi-disciplinary approach, with supportive services contributed to by educational, medical, para-medical, clinical, and paraprofessional personnel.

One of the underlying philosophies is the recognition that the growth and development of a multiple-handicapped child requires a multi-faceted program based on a thorough knowledge of the child's social, medical, and educational history including his disabilities, abilities, and assessed potential.

This paper aims to describe the procedures and process for the selection of children for admission to the Center, the eligibility criteria, the dissemination of the existence of the Center to potential sources of referral, the initial screening and intake procedures, the selection screening process by medical, clinical and educational personnel, class grouping after admission, definition of role of personnel offering educational, medical and psychosocial supportive and treatment programs, diagnostic evaluation conferences and re-evaluation conferences, and parent programs.

One of the priorities in the field of special education, prior to education and habilitation of the multiple-handicapped child is finding diagnosing, and evaluating the child who does not qualify for existing programs so that he can enter into this unique, innovative program.

The establishment of a Center for Multiple-Handicapped Children, regardless of the area of the country in which this takes place, should include some or all of the following steps:

1. Disseminate the knowledge that an educational center exists
2. Contact medical, educational, and social settings, public and private, in order to obtain referrals
3. Establish criteria of eligibility
4. Develop an intake procedure
5. Plan an educational, supportive, and treatment program
6. Provide for a program of re-evaluation as children's needs develop and change
7. Introduce a parent program and parents association
8. Arrange for an articulation program between your center and receiving school when the child is ready to move into an existing program

1. DISSEMINATION TO SOURCES OF REFERRALS

The sources with which one should communicate in order to disseminate the knowledge of a center's existence and from which referrals can be expected are:

A. The local Board of Education. (In New York City, letters were sent to bureau and units comprising the Division of Special Education and Pupil Personnel Services. These are:)

  1. Bureau for Education of the Physically Handicapped
  2. Bureau for Children with Retarded Mental Development
  3. Bureau for the Education of the Visually Handicapped
  4. Bureau for Hearing Handicapped Children
  5. Bureau for Socially Maladjusted and Emotionally Disturbed
  6. Bureau of Child Guidance
  7. Bureau of Educational and Vocational Guidance
  8. Bureau for Speech Improvement
  9. Bureau of Health and Physical Education
  10. Bureau of Attendance
  11. Special Schools Units (Schools for Socially Maladjusted, Children in Hospitals, Schools for the Deaf, School for Language and Hearing Impaired Children.)

B. Hospitals, public and private, with Departments of Social Service, Mental Hygiene, Pediatrics, Orthopedics, Neurology, Convulsive Disorders, Speech and Hearing, Cleft Palate, Muscular Dystrophy, and Rehabilitation.

C. Parent organizations for the brain-injured, mentally retarded, cerebral palsy, muscular dystrophy, and other disabilities with parents organizations.

D. Private social agencies known to serve multi-problem families.

E. Parochial schools.

F. Department of Health (Bureau for the Physically Handicapped, School Health Services, Maternal and Health Care Services, Child Health Stations.)

G. Public and private diagnostic and evaluation centers

H. Birth defects centers.

I. Visiting Nurse Associations.

J. Children's Rehabilitation Centers.

K. State Department of Mental Hygiene.

L. Department of Mental Health and Mental Retardation Services (local)

M. State Department of Hospitals.

N. Private practitioners in medicine, psychiatry, social work, and psychology, educational therapy, and paramedical disciplines.

11. ELIGIBILITY CRITERIA

Prior to establishing eligibility criteria, it is advisable to meet with every bureau director in the local board of education in order to elicit the unmet educational needs which each respective bureau has been unable to offer.

In this city, each bureau has established certain eligibility criteria for educating a handicapped child based on medical status and level of intelligence. Licensed teachers trained in educating the child with a single disability usually teach the specific child. These are the teacher of the physically handicapped, teacher of children with retarded mental development, visual handicap, deafness, neurological impairment, health conservation, home instruction, and emotionally disturbed.

The bureau directors' cooperation in carefully examining their unmet needs recommending criteria, and contributing multi-skilled teachers is an important step in setting up criteria for selection of children to a center for multiple-handicapped children.

In the initial establishment of a center, licensed personnel with superior teaching ability should be obtained from the respective bureaus. The success of the center is more likely assured if superior teachers are offered. The center's success can only bring pride to the directors through the choices of personnel trained in the bureaus and sent out to be creative, imaginative, and resourceful in uncharted areas of teaching.

The criteria finally established as eligibility requirements for admission are:

A. Disabilities: A child must have a multiple-handicap. The diagnostic categories may include those referred to as metabolic or central nervous system disabilities, birth defect children, brain-injured, cerebral palsied, mentally retarded, emotionally disturbed, blind, deaf, language and hearing impaired, seizure disorders, muscular dystrophy.

The combination of disorders may manifest themselves as disabilities in language and communication, in perception, gross motor disabilities, and/or in reading, writing, speaking and spelling.

A child may have two or more of the above handicaps.

B. Age: A child can be in the pre-kindergarten, or early childhood level, intermediate level or junior high level. (As resources develop, children in the 17-21 group would be eligible for admission).

For long range purposes, the hope is to identify handicapped children at as early an age as possible.

C. Mental Level: Children in the full range of intelligence are acceptable, that is from trainable to the upper limits.

D. Public and non-public: The Center is open to the eligible children who would be seeking education in parochial or independent schools.

In New York State, the Education Law has permitted the education of handicapped children in private schools with which the State has contracted when a public school program did not exist to meet the educational needs of such children. As public school classes increase to meet the needs of multiple-handicapped children, private settings can be expected to decline.

E. Toilet Training: The untrained child can be considered for admission but the personnel available to assist such children may be a factor in determining suitability for admission. If the children who require toilet training are of substantial numbers, there exists a need for male and female aides or matrons. Funds that increase or decrease the hiring of such personnel can affect the number of children admitted.

Many children untrained in self toileting have been denied admission to public schools, even though such problems are of neurological origin and not necessarily due to training or immaturity.

F. Program: The Center considers those multiple-handicapped children for whom there is no suitable educational program within existing or planned special education facilities.

G. Educability: Children with multiple disabilities whose primary educational needs are not clearly determinable and whose educational problems can be met only by more than one existing facility are considered for screening. Some promise of profiting from the Center's program should be expected. The Center should be a transient place for the children who can make up deficits that impede development, learning, and adjustment.

Some children are referred whose limitations in intelligence, self-care, and physical handicap are so severe that one might judge them to be "custodial" or "developmental". While the above categories are subjective to some people and of different potential to others, the decision whether to admit is usually based on the staff's belief that its program can enhance or overcome a number of limitations and prepare a child for growth and movement to another program. Since the Center sees itself as an educational setting, a prior step, placement in a developmental training program, may need to precede admission for some children.

III. SELECTION PROCEDURES AND INITIAL SCREENING

The intake process which includes the initial selection of presumptively eligible applicants, team evaluation, and recommendation for admission can operate on several levels in the early months of the existence of a Center.

When large numbers of children have to be admitted to the new Center, a variety of intake plans can be experimented with to determine which are the most efficient and effective procedures for clarification of eligibility for the Center's program, for selection of children for admission to the program, for evaluation of children's needs, and for creating programs to meet the needs.

Would it be more effective to work with an Intake Screening Team of selected disciplines or an Intake Committee of executive personnel, or a full Intake Screening Team of all disciplines including consultants and specialists who at some point screen, evaluate, support, remediate or treat a child?

Can all of the plans work under different conditions so that economy and efficiency of operation permit serving a maximum number of children and parents yet not affect the innovative, enriched, multi-service program? In anticipation of hundreds of early referrals, a variety of procedures was considered.

1. An Intake Screening Team composed of Clinical Coordinator, Medical Director, Education Coordinator and/or Teacher, Psychologist, and Social Worker and/or Guidance Counselor.

2. An Intake Screening Committee composed of Project Director, Medical Director, Education Coordinator, and Clinical Coordinator.

3. A full Intake Screening Team composed of Project Director, Clinic Coordinator, Medical Director, Education Coordinator, Social Worker, Psychologist, Guidance Counselor, Nurse, Teacher, Speech Teacher, Physical Therapist, Occupational Therapist and Paraprofessional.

In the evaluation of the intake procedure, plan number 3 was selected as the most comprehensive and informative.

In the beginning, the Clinic Coordinator became the initial reviewer of incoming referrals whose job it was:

1. to determine if the child met the eligibility criteria
2. to determine the problems that needed referrals to other community resources.

If the referral problem did not meet the eligibility criteria for the educational program of the Center, the Clinic Coordinator would suggest more appropriate resources to the referral source, either by letter or telephone call to the referring source.

The above tasks performed by the Clinic Coordinator were really social work and guidance roles but in view of the hundreds of initial referrals, we were able to sort out those that would not require full study and assign to social workers and guidance counselor those children needing more intensive review. Eventually, the screening role of the Clinical Coordinator can be delegated to social worker or guidance counselor.

If a referral, judged to be presumptively eligible, came from such source as a physician, social worker, psychologist, or other professional personnel connected with an agency, clinic, hospital, treatment center, health or welfare setting, or a unit of the Board of Education,a form letter was sent requesting medical, psychological, psycho-social history and educational reports,if missing in the referral material.

At the point where the Center was in a stage of renovation, and prior to the actual admission of children, 2,000 letters were sent to community sources announcing its impending establishment so that most referral sources knew the kinds of referral information that was needed.

If a self-referral was received; a telephone call was made to the parent to indicate the kinds of information needed for initial evaluation.

If a parent needed help with the application procedures because of confusion, language barrier, or any interfering reason, interview with Clinic Coordinator or other designated person was offered.

Intake Interview

When a referral was judged to be presumptively suitable for intensive study, the child selected for initial screening was assigned to a social worker or guidance counselor by the Coordinator of Clinical Services.

1. An appointment for intake interview was offered.

2. An application form was mailed to the family with instruction to bring in the completed form on date of interview with social worker. If it was felt that the completion of the application form might be difficult, the clinical worker filled it out together with the applicant at the initial intake interview.

The application form requests such information as:

a. Family History
   Identifying data such as birth date of child, place of birth, hospital in which born
   Identifying data regarding parents, siblings, relatives in household.
   Social data regarding parents such as birth place, education, occupation, current employment, current housing arrangement

b. Source of Referral

c. Contacts with other medical and social agencies, individual professionals (eg. psychologists, social workers, speech therapists, physical therapist); school services (Bureau of Child Guidance); Court, State Schools, State Hospitals).

d. School History - Current school, special education programs, previous education history (regular or special schools).

e. School History - Social History, guidance data, anecdotal cumulative record data, psychological and achievement tests, behavioral adjustment data.

f. Levels of functioning in activities of daily living (coordination, visual, motor, dressing, playing, eating).

g. Speech and language development.

h. Birth, developmental, health, and immunization history.

i. Obstetrical history.

Condition and appearance of child prior to birth, and after birth; birth weight.

j. Special problems of child in reference to hearing, vision, speech, toilet training, orthopedics, appliances, wheelchair, allergies, seizures, medication, diet. dressing.

k. Family Medical History (Parents, siblings, grandparents, relatives) with reference to seizures, retardation, diabetes, chorea, tuberculosis, heart disease, hospitalizations for mental illness, metabolic disorders etc.

l. Camp history - day camp, sleep-away camps.

lV. SCREENING PROCESS

The intake screening process includes medical, clinical and educational evaluations in addition to speech, physical therapy and occupational therapy reports.

The personnel involved in the above screening are:

Clinic Coordinator
Medical Director
Educational Coordinator
Social Worker
Psychologist
Guidance Counselor
Teacher
Nurse
Speech Teacher
Physical Therapist
Occupational Therapist

As this center is the local Center for the education of multiple-handicapped children from the five counties that comprise New York City, an attempt is made to complete all the evaluations in a single day. This approach reduces travel from distant areas, sometimes requiring the use of subways and bus. It also reduces the need for working parents to absent themselves from employment for more than one day.

V. FUNCTIONS OF DISCIPLINES

A. Clinic Coordinator

Coordinates the intake screening process by the intermural coordination of the medical, clinical, and educational personnel involved in the interviewing, examining, evaluating, assessing and planning for children and parents. Initially, this involves selecting for intake screening the presumptively eligible children who are seen directly at the Center.

After reading and reviewing referrals, cases are assigned to social workers and guidance counselor for intake interviews. The clinical coordinator establishes the schedules for initial interview and examinations by the above personnel and prepares schedules for subsequent case conferences. At the Joint Screening Conferences the Clinical Coordinator participates actively in matters of disposition and planning for applicants. After a child is admitted to class, the Clinic Coordinator serves as one of the consultants to all disciplines in psychological and psychoeducational matters. Eventually he participates in the selection, planning, and disposition of the incumbent children who are judged to be ready for "graduation", i.e.: transfer to existing school programs for which multiple-handicapped children were not previously ready.

B. Medical Director

Prior to the elaborate evaluations by clinical and educational personnel, the Medical Director conducts a preliminary comprehensive medical evaluation of the child.

In almost every case, medical data is available about the handicapping condition, in addition to information from clinical procedures, laboratory tests, and x-rays. Supplementary information is obtained from interview with parents. A diagnostic impression is made.

C. Social Worker and Guidance Counselor

Both the social worker and guidance counselor, who function in the intake process of selection

1. Orient the parent to the purpose and program of the Center.
2. Seek to understand the child's problem for which family seeks attention.
3. Orient the parent to the intake screening process, diagnostic evaluation, and plan for prescriptive teaching.
4. Elicit the family's reaction to and determine the effect of the handicapped child in the family, if any; elicit problems in managing the child at home; ways in which help is needed.
5. Review the application form and help complete the areas not recorded.
6. Assess the family reaction to the child's disabilities and to involvement in the program.
7. Determine how the child functions at home, how he relates to all members of the family, how he spends his time, efforts at independence.
8. Identify problems in management, associated family problems, need for communication with agencies.

9. Assess need for support, for visiting nurse, or other assistance,

10. Describe any problem (personal, family, group, emotional, physical) which has affected or could affect the learning process of the child.

11. Arrive at a psychosocial assessment,,treatment plan, or services needed for success in the educational program.

D. Psychologist

Evalautes every child by administering at least one test even though a report may be available from another source. However, if in the judgment of the psychologist the data available contributes to an understanding of the child for screening purposes, then first hand observation would suffice. The Center's focus requires an understanding of the child's detailed functioning. The psychologist's observations of the emotional, behavioral, motor , perceptual, and conceptual functioning are essential. The learning gaps and sensory areas in which training is needed will contribute to structuring an educational program.

E. The Teacher

Offers an educational evaluation of:

a. communication skills, (oral and written expression, listening acuity and vocabulary comprehension)

b. number knowledge (counting and writing numerals)

c. time concepts, measurement, shapes, problem solving ability

d. color knowledge (naming and identifying colors)

e. self awareness (knowledge of name, sex, age, parts of body)

f. reading for comprehension, recognition

g. behavioral characteristics

F. The Speech Teacher

1. Assesses the child's level of functioning in areas of receptive and expressive communication.

2. Assesses the communication processes, visual, motor, and perceptual functioning.

3. Evaluates inner language

4. Prepares a prognosis of language development

G. The Physical Therapist

1. Examines the child, notes the disabilities resulting from the congenital or contributory condition.

2. Determines whether safety problems derive from the condition.

3. Reports on whether appliances or braces are needed so as not to interfere with the educational program.

4. If the child is in an active treatment status with another clinic, the physical therapist reports on the rehabilitation procedures recommended by the other clinic. The relationship between the primary treatment agency and the physical therapist in the Center, so far as determining where one treatment will be conducted and by whom, is worked out by the physical therapist and the treatment agency, with the knowledge of the Medical Director.

H. The Occupational Therapist

1. Examines the child described above according to the principles of the discipline in assessing a handicapped child needing an occupational therapy program.

VI. Diagnostic Evaluation Conference

After the Intake Screening Team members have completed their individual examinations, a diagnostic evaluation conference or joint screening conference, as it is called, is scheduled by the Clinic Coordinator at which the information from all disciplines, data, observations, and impressions are shared and integrated, with recommendation for acceptance or nonacceptance to the Center. The personnel of agencies who referred the family are invited to attend the joint screening conference. If judged to be nonadmissible to the Center, an alternative recommendation for educational placement is made.

At the weekly case conference, where selection of admissible children is determined, each discipline or speciality presented their findings and recommendations in accordance with the following suggested guidelines.

A. Medical Director

Described the obstetrical, birth and developmental history, detailed the physical examination and gave a diagnostic impression of the medical findings.

B. Social Worker & Guidance Counselor

Presented a psycho-social evaluation of the total family situation, both child-focussed and parent-focussed, family strengths, siblings and parent relationships, parental willingness to place child in another setting if the program is unable to meet the needs of the child; education history in other educational settings, description of the learning, behavior, and personality problems which made necessary referral to the Center, services needed in and out of the Center to help the educational program and social adjustment.

C. Psychologist

Presented a summary of tests of ability and personality, of the child's central processes, use of the sensory, motor organization, the ability to adapt to the school environment and recommendations for educational placement.

D. Teacher

Indicated the strengths and assets on which to build an educational program; reported on the gaps in learning which would require remedial services.

E. Speech and Hearing Therapists

Presented observations on the child's peripheral and central systems; receptive and expressive levels; the child's readiness to participate in a program of speech and language development.

F. Physical Therapist

Reported on the findings of her examination as described above.

G. Occupational Therapist

Participated in the staff conference and recommended a program that could be integrated with both the educational and physical therapy program. She also recommended a program of daily activities for the child.

The summary report of this Joint Screening Conference was dictated immediately by the Medical Director. Alternative recommendations are made on behalf of every child not accepted for admission and where feasible are implemented by Medical Director, social worker, guidance counselor, or psychologist.

VII. EDUCATIONAL, MEDICAL, CLINICAL SUPPORTIVE AND TREATMENT PROGRAMS

The Intake Screening Process and the Diagnostic Evaluation case conference has resulted in a detailed understanding of the admissible child from a medical, psychological, social, and educational point of view. The guidelines followed are an integration of many disciplines, each contributing to the total educational experience, rather than a multitude of isolated services.

As each child differs from each other, the "level" and "intensity" of services and education differs for each child.

An initial step that must be resolved prior to the beginning of the educational program is the grouping of the children into appropriate classes.

Three approaches can be followed. Grouping by 1) diagnostic group 2) developmental level; or 3) age level.

The diagnostic group could include children with

a. learning and communication disorders
b. behavioral disorders
c. severe physical disabilities presenting problems of physical safety management.

Suggested levels in the Developmental Group are:

a. gross motor
b. perceptual
c. language
d. social skills
e. sensory areas needing training in perceptual and conceptual development

Suggested Age Level are:

a. 5-6, 7-8, 9-10, 11-12, etc.

In a survey of the first sixty children admitted to the Center, a study was made of the diagnostic categories of each child. The areas studied were: age, physical handicap (other than visual, hearing) neurological, seizures, cerebral palsy, aphasias, mental level, (retarded, average), emotionally disturbed (behavioral, neurotic, psychotic), incontinence, wheelchairs.

Of the entire group only four children had four common areas but they were age 5, 9, 12, 15. It was finally decided to group children by age, keeping them as close to a level as possible. Exception was made with the hearing handicapped, who in general, were placed by handicap because three of the classrooms were equipped with sound magnification units,

In the educational phase of the program, with its varied supportive and treatment programs, each teacher, who was usually trained in the education of the single disability child, was faced in the initial months of the school's origin of observing and assessing each child and establishing a tentative educational program. Although children were close to each other in age, they varied in the number of handicaps, and levels of ability. The educational program varied for almost each child. Under the teacher's direction and supervision, paraprofessional or educational assistants assisted in teaching children individually or in several groups.

After the children are placed in classes and the educational program has begun, the roles of each discipline often come into play.

A. Education Coordinator

The Education Coordinator has a major role in developing and coordinating the total educational program at the Center. If the teacher finds that a child's placement or grouping is not in the best interest of the child, or other children in the class, she discusses the problem directly with the Education Coordinator who can arrange an interclass transfer. If the problem is severe, the Educational Coordinator seeks the help of the Joint Screening Team of all disciplines through a case conference.

B. Medical Director

1. The physician examines each child periodically. If coordination with a medical or treatment agency has been developed, the plans for medical management, treatment and follow-up are within the judgment of the Medical Director.

2. He advises the treatment or referral agency of medical findings, and reports to the active physician possible indications for prescription or change of medication.

C. Nurse

1. Maintains medical records
2. Receives referrals from teachers or other disciplines.
3. Brings to doctor's attention and other disciplines involved with children the medical and physical problems observed in the center.
4. Consults with parents in programs of diet, nutrition, personal, and oral hygiene after discussion with physician.
5. Refers children to medical facilities for treatment, after reporting the plan to other disciplines; coordinates with Visiting Nurse Services and other health agencies.
6. Informs all disciplines of scheduled medical examination and meets with parents if necessary.

D. Speech Teacher

1. Develops a speech and language program by prescription.
2. Supervises a communication training program to be carried out by parents at home and instructs parents in exercises that might be carried out at home.
3. Maintains records of treatment and progress of children.
4. Submits a written periodic report of progress of the children,such report to become a part of the profile on each child.
5. Participates in case conference of special problem children and those "graduating" to other existing programs.

E. Social Worker

1. Carries children as active cases and offers casework counseling to parents.
2. Offers individual intensive therapeutic help to selected children.
3. Participates in case conferences that pertain to interclass transfers, to special problems, to children "graduating" from the Center to established existing programs for which they may be judged ready.
4. Participates in a parent education program and group counseling program with parents and/or children.
5. Consults with teachers on psychosocial problems affecting learning and adjustment.
6. Participates in extensive summer camp placement program, day camps, and sleep-away camps.

F. Psychologist

1. Observes, examines, and tests children both at intake and after admission to Center in order to establish baseline for growth studies and comparative achievement levels.
2. Consults with teachers on children presenting psycho-educational problems.
3. Carries selective children for intensive therapeutic service after conference with clinic coordinator, social worker, and/or guidance counselor.
4. Participates in case conferences pertaining to interclass transfers, "graduation" to other educational programs.
5. Participates in teenage group guidance and group counseling programs.

G. Guidance Counselor

1. Carries a caseload of families whose children have been admitted to school, offering counseling services to parents and meeting concrete needs.
2. Offers guidance counseling to selected children
3. Participates in case conferences that pertains to interclass transfers to special problems, to children graduating from Center to established existing programs for which they may be judged ready.
4. Consults with teachers on learning problems of children
5. Participates in extensive summer camps placement program, locating camp resources and placing children with multiple handicaps in appropriate camps, day or residential.

H. Teacher

1. Carries out an educational program which, from a total knowledge of the child developed at intake, takes account of handicap and differential strengths and weaknesses
2. Develops innovative methods, materials, and techniques
3. Maintains the Pupil Evaluation Profile, progress records, and cumulative records
4. Shares knowledge with other disciplines at conference

I. Physical Therapist

1. Carries out the medical prescriptions for physical therapy and directs the functional training of the children under the supervision of the medical director.
2. Maintains adequate records of treatment and progress of the children.
3. Submits a written annual report of the progress of the children at the end of each school year to persons and agencies concerned. Such report will become a part of the profile on each child.
4. Instructs parents in the specific exercises of the child.
5. Makes home visits to review with the parents the exercises previously demonstrated at school; advises about the general physical handling of the child; explains program aims; recommends adaptation in the home which would facilitate independence of the child.
6. Trains the children in such activities as therapeutic exercises, ambulation, application of braces and transfers for the purpose of developing the child's independence.
7. Maintains equipment in the PT room.
8. Recommends to the Medical Director any needed repairs or adjustments of the children's appliances.
9. Suggests ordering PT equipment as needed.
10. Instructs the aides in proper handling of the children as pertains to application of braces, ambulation, transfer and toileting for the continuity of the child's program.

J. Occupational Therapist

1. Carries out medical prescriptions for occupational therapy and directs the functional training of the children in the Center under the supervision of the medical director.
2. Maintains adequate records of treatment and of progress of the bhildren.
3. Submits a written report of the progress of the children in the Center, at the end of each school year to the persons or agencies concerned. Such report will become a part of the profile on each child.
4. Makes home visits to review with parents the exercises previously demonstrated at the school; to advise about the general physical handling of the child; to explain program aims; to recommend adaptations in the home which would facilitate more independence of the child.
5. Trains the children in such activities of daily living as self-feeding, self-dressing, self-toileting, therapeutic exercises, perceptual training and other special skills.
6. Maintains OT equipment and supplies, and suggests ordering them as needed.
7. Instructs the aides in the proper handling of the children as pertains to self-feeding, self-dressing, self-toileting for the continuity of the child's program.

VIII Reevaluation Conferences

After a period of intensive education and support, which could be a year or more, the school population is reviewed.

The tailored program with its supportive services is reviewed for possible changes. Perhaps a transfer to a less sheltered Board of Education special program or changes within the Center program are indicated. The reevaluation may determine if there is a need for new prescriptions or grouping.

Although all of our children have two or more handicaps, the intensive educational program with its supportive, medical, psychological, social, guidance, therapeutic and tutorial services seems to strengthen some of the children and decreases the weaknesses which prohibited success in existing programs.

The Center for Multiple Handicapped Children attempts to "rotate" or transfer out the children who are judged to be ready to move into existing special education programs. Our paramount concern is that the setting to which the child is recommended is the right one. We are interested in moving our children only when we find them so ready that the new setting will provide a continuation of the growth and development begun here.

In order to make the "graduation" effective, the new bureau to which a child is recommended must feel that the child is ready for their program and that the child can benefit from their efforts. To complete the determination of readiness for transfer requires the cooperation of the new bureau. We invite the supervisory personnel who will be working with the new teacher to visit our Center, observe the child, and confer with specific team members who know the child. Such consultation leads to a most effective selection of children and long range economy in selective placement.

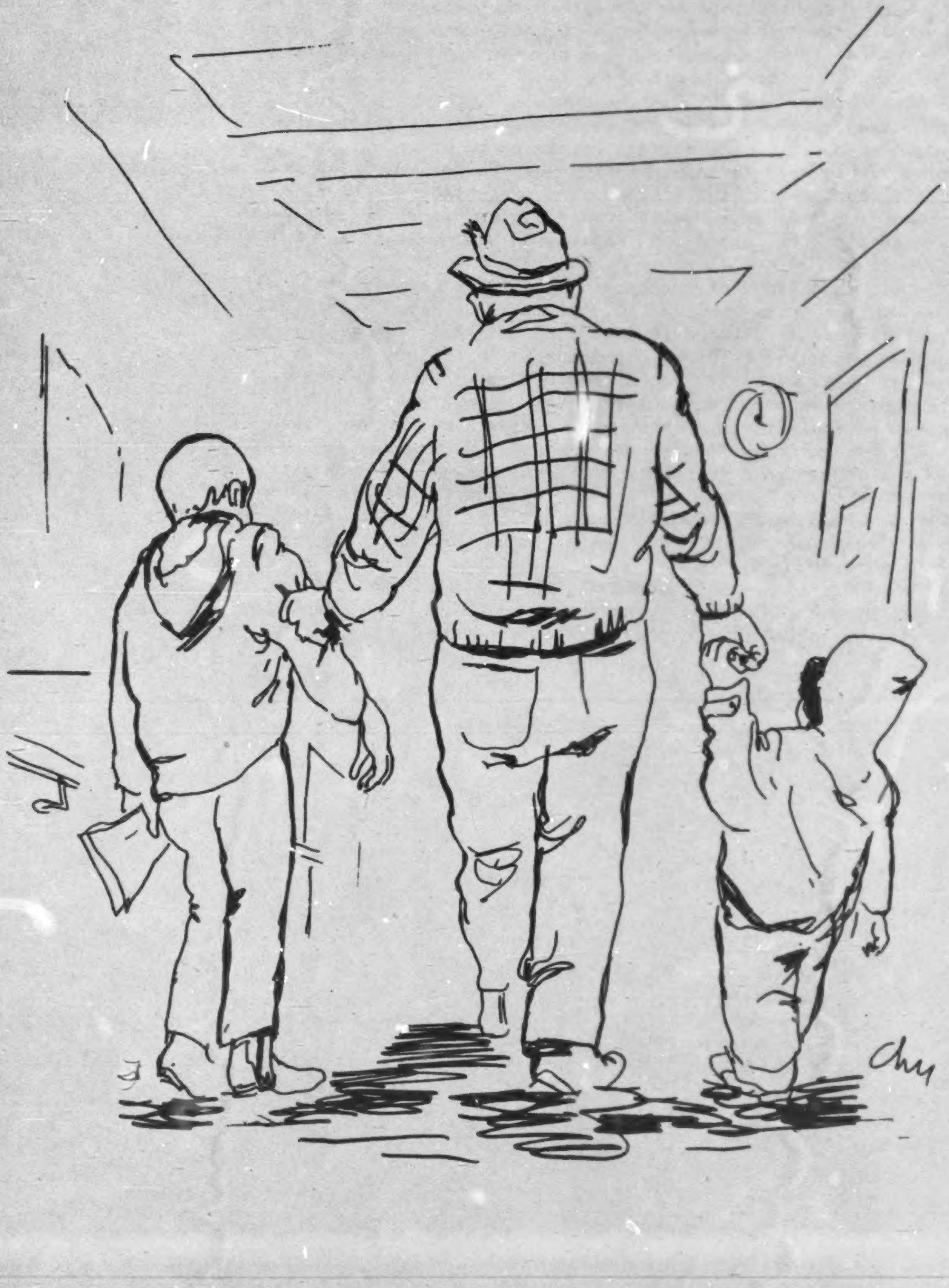
The beneficial effects on child and parent, teacher and supervisor are obvious. In addition, children whom we transfer are followed by the social worker and guidance counselor, thus establishing a bridge of communication that is reassuring to both children, parents and the new teacher.

We recognize that most multiple handicapped programs cannot make the kind of progress which would enable all children to move on. Some will be "permanently placed". The policy of "rotation" and "graduation" will continue with the opening of multiple handicapped centers in the other boroughs of the city.

1X. Parent Programs

1. The participation and cooperation of parents in the education and rehabilitation of multiple handicapped children is a basic ingredient in a parent program.
2. The parents must be involved and have access to all disciplines working with children.
3. Parents should be kept abreast of all programs, systems and services available to children and parents in the center and community.

4. Parents must be helped to understand the center's program, the varied and multiple goals for each child, the assessed potential, the uneven growth, and the translation of program and implementation from school to home.
5. A parent program offers parent education, parent counseling and parent therapy. A parent education program, involving all staff members for the purpose of giving informal guidance has been developed. Parents are invited to a series of lectures by staff, each describing his program. Parents are divided into groups for discussions with specific disciplines describing a specialty, or into groups discussing the goals of a specific prescription.
6. A major instrument of the parent program is the Parents Association, with its elected officers, connected to the center administration through a liaison staff member, either social worker or guidance counselor. The liaison staff member meets with the Executive Board regularly and assists in their planning the regular monthly program at which time parents are apprised of the variety of school program, the problems that may affect a program and new undertakings such as the formation of a center Boy Scout Troup. Parents sit on an Advisory Council that meets with Center administration. Parents conduct fund raising programs that may meet small unmet needs of children such as carfares, and uniforms for the center chorus.
7. A broad professional integrated, coordinated, cooperative team has been described. The success of a center's operation is enhanced when parents are on the team.



CENTER FOR MULTIPLE-HANDICAPPED CHILDREN
105 East 106th Street, New York, N.Y. 10029
722-0605

INTAKE HISTORY

Child's Name______________________________

Social Worker_____________________________

Guidance Counselor________________________

Prepared By:

Gerald Ehrlich, M.S.W., M.S.Ed.
Coordinator of Clinical Services

INTAKE HISTORY

1. IDENTIFYING DATA

11. SOURCE OF REFERRAL

111. FAMILY COMPOSITION

lV. HOUSING

V. CONTACTS

Vl. EDUCATION

Vll. MOTHER'S MEDICAL HISTORY DURING PREGNANCY WITH CHILD

Vlll. OBSTETRICAL HISTORY

lX. CONDITION AND APPEARANCE OF CHILD AT BIRTH AND AFTER BIRTH

X. DEVELOPMENTAL HISTORY OF CHILD

Xl. CHILDHOOD DISEASES

Xll. IMMUNIZATION HISTORY

Xlll. PROBLEMS THE CHILD HAS CURRENTLY

XlV. FAMILY MEDICAL HISTORY

XV. TWO PERSONS, OTHER THAN PARENTS, TO BE CONTACTED IN CASE OF EMERGENCY

XVl. PARENT ORGANIZATION DEALING WITH HANDICAPPED TO WHICH PARENTS BELONG

XVll. SUMMARY

DATE ________________

0

1. **IDENTIFYING DATA**

A. **Child's Name**

Last **First** **Middle**

- -

B. **Address** Street -

City -

State -

Zip Code -

Apartment Number - - - - - - - - - - - - - - - - - -

New Address -

C. Telepnone Number -
(Home) (Business)

D. If no telephone, where can family be reached or message left :

- -

E. Child's Birth Date -

F. Pâace of Birth -

G. Hospital (Name and Address) - - - - - - - - - - - - - - - - - -

- -

11. **SOURCE OF REFERRAL**

Who referred family to Center (Person, Agency, Organization, Clinic, Hospital, Self, (Address)

- -

111. **FAMILY COMPOSITION**

A. Father:

1. First Name -
2. Birthplace -
3. Birth Date -
4. Age at time of child's birth - - - - - - - - - - - - - - -
5. Occupation when employed - - - - - - - - - - - - - - - - -

111. FAMILY COMPOSITION

6. Currently employed - - Yes ( ) No ( ) - - - - - - - - -

7. Business Address & Telephone Number if Employed - - - - -

- -

8. Financial Status: Public Assistance: Yes ( ) No ( )

9. School, grade completed - - - - - - - - - - - - - - - - - - -

10. Diplomas: Elementary ( ) High School ( ) 11. Degrees - - - -

12. Address if not living at home - - - - - - - - - - - - - - - - -

B. Mother:

1. First Name -

2. Maiden Name -

3. Birthplace -

4. Age at time of child's birth - - - - - - - - - - - - - - - -

5. Birth Date -

6. Occupation when employed - - - - - - - - - - - - - - - - - - -

7. Full time ( ); Part time ( ) - - - - - - - - - - - - - - - -

8. Occupation prior to marriage - - - - - - - - - - - - - - - -

9. Currently employed: Yes ( ) No ( )

10. Business Address & Telephone Number - - - - - - - - - - - - -

- -

C. Brothers and Sisters (List oldest child first)

1. Name	2. Birth Date	3. Lives Home (Yes) (No)	4. Public School No.	5. Grade	6. Privare or State Aided School	7. Occupation

D. Other persons living in the home

1. Name ____________ 2. Relationship to child ____________ 3. Birthdate or age ____________

4. Birthplace ____________ 5. Occupation ____________ 6. Reason left home ____________

lV. HOUSING

A. House ( ) or apartment ( )

B. Number of rooms ____________

C. Type of heat: Steam ( ) Coal ( ) Kerosene ( ) Other ( )

D. What floor do you live on? ____________

E. Does the apartment house have an elevator: Yes ( ) No ( )

F. Does child have separate room: Yes ( ) No ( )

Shares a room ____________ with whom ____________

Separate bed ____________ shares a bed ____________

G. Do you live in a project? Yes ( ) No ( )

Name & Address of project ____________

____

H. Is there any problem in getting child in or out of the apartment?

If yes, describe ____________

____

V. CONTACTS

A. List all medical, social agencies, and individual professionals who have known or seen the child; include addresses.

1. Medical doctors and hospital services: (Use reverse side if necessary)

a. Name b. Address c. If clinic, give clinic #

2. Psychological Services: (give name and address of clinics, agencies or private practitioners who have seen the child).

3. Social agencies: i.e. Department of Welfare; agencies, like Catholic Charities, Jewish Board of Guardian, Salvation Army, etc.

4. School Services (Bureau of Child Guidance, Bureau of Education & Vocational Guidance, Bureau of Attendance, etc.

5. Courts, State Schools, State Hospitals, etc.(Name, Address, Year).

VI. EDUCATION 1.

A. School, child is attending

1. Number -

2. Name -

3. Address -

4. Grade or Name of Class (if it is a special class, e.g. Brain Injured, C.R.M.D., Junior Guidance, etc):

   -

5. Teacher's name -

6. Principal's name, -

7. Guidance Counselor's name, - - - - - - - - - - - - - - - - - - -

8. Did child attend a nursery or Kindergarten (Name, address, at what age)

   -

B. Previous Education History (List the schools, other than the one above, most recent one first)

1. Name and address of school	2. Dates attended	3. Grade	4. Regular or special (if special name type of class)	5. Reason for leaving

C. Camp History (Name of camps attended, location of camp; Headquarters, if known; dates attended)

EDUCATION 11

Extracts from records of schools or agencies in areas of:

A. Mental Level	Date of Test	Test Used	I.Q. Score (if indicated, Verbal, Performance Full Scale)	Grade Level

B. Reading Level

C. Other Achievement Levels

D. Math Level

EDUCATION 111

A. Reading:

1. above grade level________
2. at grade level__________
3. 1 year below __________
4. 2 years below __________
5. no measurable performance ________

EDUCATION 111

B. Arithmetic

1. above grade level ________
2. at grade level __________
3. 1 year below ___________
4. 2 year below ___________
5. no measurable performance _______

Tests Utilized: ______________________________

C. Social Development

Peer relationship and degree of independence in self-care (dressing, toileting, feeding).

1. above age level _________
2. at age level ___________
3. mildly below age level
4. moderately below age level _____
5. severely below age level ________

V11. MOTHER'S MEDICAL HISTORY DURING PREGNANCY WITH CHILD

(Describe freely the illness, infections, and accidents during pregnancy, noting the periods or months, e.g. First three months, second trimester, third trimester).

When discussing illness, note the severe illness not covered under infections (kidney infection, measles, viral infections). Also, note toxemias (swelling of hands and feet, high blood pressure, convulsions, severe headache); bleeding (when, during pregnancy); vomiting (when and how much); surgery or serious accidents; unusual worry, emotional strain, or upsetting event. Medications or injections during pregnancy and unusual effects; excessive smoking-number of cigarettes per day).

V111. OBSTETRICAL HISTORY

A. Pregnancy

1. Length of Pregnancy - - - - - - - - - - - 3 Were you put to sleep --

2. How long in labor - - - - - - - - - - - - 4 Did you have spinal - -

B. Type of Delivery

1. Spontaneous — 4 Head first
2. Forceps — 5 Breech (feet or buttocks first)
3. Caesarean

C. Total number of pregnancies (including miscarriages) - - - - - - - -

D. Number of miscarriages - - - - - - - - in which month - - - - - -

E. Child was - - - - - - - - - - - - - - - pregnancy

F. Are you RH negative Yes - - -No - - - - - - - - - - - - - - -

G. Was mother x-rayed during pregnancy? Yes - - No - - (When)- - -
(Name and address of Hospital, Clinic, or Private Doctor)

- -

- -

H. Was the pregnancy easy or difficult? Describe in mother's own words:

- -

- -

I. How did the pregnancy compare with others:

- -

- -

IX. CONDITION AND APPEARANCE OF CHILD AT BIRTH AND AFTER BIRTH

A. Kindly answer "yes", or "no", or "unknown". If answer is "yes", how long condition lasted from time of birth and type of treatment the child received.

(Use other side if necessary)

1. Did the baby appear yellow?________if yes, what day__________
2. Did the baby have difficulty breathing?____________________
3. Did baby have blue lips?______________________________
4. Did the baby have convulsions or twitching at or soon after birth?

   Describe______________________________________
5. Weight of baby at birth?______________________________
6. Was oxygen used?__________________________________
7. Was baby in an incubator?_______how long?_______________
8. How long was the baby in the nursery?____________________

X. DEVELOPMENTAL HISTORY OF CHILD

A. Indicate as accurately as possible the age or in months and years at which the child did the following:

1. Held head erect when lying on stomach or balanced head______

____

2. Followed objects with eyes______________________
3. Noticed noises______________________________
4. Rolled over alone from back to stomach______________
5. Played with hands____________________________
6. Reached for familiar persons____________________
7. Sat independently____________________________
8. Crawled____________________________________
9. Stood without support__________________________
10. Walked alone, unattended, or without support__________
11. Ability to climb stairs, after walking______________
12. Talked (babbled) imitated sounds______; first word, when____

____

13. Excessive drooling____________________________
14. Started counting______________________________
15. First tooth__________________________________
16. Fed self with a spoon__________________________
17. Put on own clothes____________________________
18. Buttoned buttons______________________________
19. Tied shoe-laces______________________________
20. Handedness; Right____________Left______________

B. Toilet training

1. At what age was child bladder trained? (a) Day____________________
(b) Night__________________

Was this complete or partial______________________________________

2. At what age was child bowel trained?__________________________

C. Feeding History

1. Was child breast or bottle fed?___________________________________

2. Did you have any trouble in feeding the child as an infant__________

Describe:____

____

3. When were strained foods introduced______Solids________________

4. Does the child have trouble in chewing or swallowing foods_________

5. Is the child a "fussy", or "difficult" feeder?______________________

Describe:____

____

XI. CHILDHOOD DISEASE

A. What disease did the child have? At what age?

(include such diseases as whooping cough, measles, mumps, chicken pox, scarlet fever, bronchitis, asthma, pneumonia, others)

B. Did child have any operation?

kind, age, hospital

C. Accidents? Kind, age, hospital or doctor

XII. IMMUNIZATION HISTORY

A. Diphtheria)
Pertussis) DPT -
Tetanus)

B. Smallpox
Vaccination -

C. Poliomyelitis
Salk (injection)
Sabin (oral) -

D. Measles Vaccine -

E. Flu Vaccine -

F. Rubella -

G. Mumps -

H. Tuberculin Test -

I. Recent Tetanus Booster -

X111. **DESCRIBE FREELY ANY PROBLEMS THE CHILD CURRENTLY HAS IN REFERENCE TO THE FOLLOWING**

A. Is there a hearing difficulty? ( ) At what age did you first notice it? ( )

B. Does the child have any eye difficulty or vision problem? ( ) Does child wear eye glasses? ( )

C. Any speech or speaking problem?

D. Does child have any problem referable to chest and related organs?

E. Does child have an orthopedic problem?______Describe__________

1. Does child wear brace or other appliances or use a crutch? Describe____

2. At what age prescribed__________ By whom? (Doctor or Clinic___
____

3. Are there difficulties in the use of the appliance?__________
____

4. Does child use a wheelchair?_____Full time?_____Part time_____

Does he operate it by himself?______________________________

F. Allergies

1. Is child allergic to any food or drug? If so, describe________

2. Is child on a medical program? If so describe clinic, doctor, program____

G. Does child have convulsions or seizures?______________________

1. With fever____________Without fever______________________

2. At what age did convulsions start?________Stop___________

3. Has child ever taken anti-convulsant medication?_____What____

4. Does child now take anti-convulsant medication?____________

What kind?______Which Doctor or clinic prescribed and

supervises?____

What amount?____

H. Describe freely previous therapies, physical,occupation, speech, source, amount.

I. Behavioral difficulties: on a separate page, discuss areas of behavior, discipline, play, sleeping, dressing, etc. Note in particular, relationships with siblings.

XIV. FAMILY MEDICAL HISTORY

(Describe freely any conditions that are referable to or related to the child's condition, congenital, inherited, etc.)

Have any members of the family (child's parents, brothers sisters, cousins, grandparents, aunts, uncles) had a related illness?

Possibly include relationship to child, age when condition begun, does condition exist now, is condition improved, controlled, non-existant)

(Conditions which one may discuss with family are: epilepsy, mental retardation, venereal diseases, chorea, diabetes, tuberculosis, cancer, nervous breakdown, hospitalizations for mental illness, heart disease, cerebral palsy)

XV. LIST TWO PERSONS, OTHER THAN PARENTS, TO BE CONTACTED IN CASE OF EMERGENCY

Name	Name
Address	Address
Telephone	Telephone

XVI. LIST ORGANIZATION DEALING WITH THE HANDICAPPED IN WHICH PARENTS HOLD MEMBERSHIP

LIST MEMBERSHIPS IN UNION, FRATERNAL, RELIGIOUS, PROFESSIONAL, CIVIC ORGANIZATION

XV11 GUIDELINE FOR INTAKE SUMMARY

A. The focus of the intake summary should be on the psycho-social factors in the home, the school (if previously attended), and the community which will impede or enhance learning, also the factors that might contribute to management problems or reduce them in the classroom.

B. Suggested topics for exploration are:

1. Child's problems for which family seeks attention or service
2. Family's reaction to
   a) the handicap
   b) the management of child
   c) the future outlook
3. Effect of the handicapped child on the family
4. Problems in managing the child at home
5. Ways in which help is needed and family's expectation of Center

C. Describe on a separate sheet any medical or clinical material which the family feels is highly confidential and not to be released without their authorization.

MEDICAL PROGRAM

Dr. Alfred L. Scherzer, Medical Director

I. Introduction:

Among the major innovative features of the Center is a strong medical component. Its functions broadly include initial medical screening of prospective students; periodic medical re-evaluation of all students; consultation service to staff and community agencies, physical and occupational therapy services, and training programs for a variety of health personnel. In all these functions the underlying philosopy is one of close integration of all medical and treatment service with the educational, social service, and community programs to form a total habilitation approach to the multiple-handicapped child.

II. Staff:

Personnel include a Medical Director with a background in pediatrics (specializing in care of handicapped children) and education; and a graduate nurse with qualifications in school health. Both the occupational and physical therapists have previous experience with children's handicapping conditions.

III. Facilities:

A medical office provides ample space for medical examinations for acute emergency care and a separate rest area for children who must be observed. All medical records are maintained for easy access. Simple emergency materials are available. Health education materials and sources are arranged for teaching staff.

Physical and occupational therapy services each maintain a separate room with full equipment. In addition, materials and equipment are available for use by teachers and other staff within classrooms or for special programs.

For medical emergencies children are brought to the emergency room of The Flower & Fifth Avenue Hospital (New York Medical College) - a short distance from the Center. Should special medical evaluations including laboratory services be required, referrals are made directly to the Cornell University Medical College (affiliated with the Center) or to an appropriate medical facility within the City already known to the student.

IV. Intake Procedure:

All health staff participate in the screening process for new applicants. Each child is seen for a full medical evaluation which particularly emphasizes developmental deficits. Physical therapy evaluation stresses movement, position, and ambulation.

IV. Intake Procedure:

In occupational therapy the areas include self care, hand use, and perceptual-motor areas. The health staff are part of the regular weekly intake meetings and participate in decisions regarding suitability of applicants.

V. Ongoing Evaluations:

All children in the Center have a complete medical re-evaluation annually and in certain instances more frequently. A parent conference is held during the examination if possible and information concerning the child's functioning and behavior is obtained on questionnaire at the time from parent and teacher. Medical recommendations are discussed jointly with physical, occupational, and speech therapies, social service, and the teacher. Frequently the hospital, clinic or private physician known to the family is contacted directly regarding medication, need for special services, and tests. A special medical re-examination form is used (see attached) and is included in the full medical record of each child.

Full hearing evaluation and periodic re-evaluations are conducted cooperatively with the Speech-Hearing Department of the Hunter College Institute for Health Sciences. This facility is located in the same building as the Center and provides hearing aid examination as well. Findings and recommendations form part of the medical record and are also sent to the physician or health facility where the child is seen for follow-up.

Similarly, re-evaluations are regularly performed in physical and occupational therapies and conferences are held with relevant staff regarding recommendations. These evaluations are also recorded on special forms which become part of the full medical record.

All health information on each child also is kept in the individual record file. Past health status immunizations, current medications, and a log of any visit to the medical office all are included in the record.

VI. Medications:

Medications prescribed by an appropriately licensed physician, hospital, or clinic are dispensed by the nurse if it is required that the dose be given during the school day. No medication is prescribed at the Center. Drugs given generally include anticonvulsants, hypo-active agents, and occasionally antibiotics. Observation of reaction to drugs during the school day affords an opportunity to assess appropriatness of drug and dose. Close contact is maintained with the physician or clinic and frequent recommendations are made regarding drug changes. With this system it has been possible to alter or completely eliminate medication in many cases. This is particularly true for the hyperactive child who, in the setting of the Center, may have considerable improvement in behavior without drugs.

VII. Emergencies:

While the medical office maintains space, equipment, and some facilities for emergency care, the primary source for such treatment is at the nearby Emergency Room of the Flower & Fifth Avenue Hospital. Children are brought by wheelchair or car as needed. Close liaison is maintained with the hospital for follow-up care.

VIII. Medical Consultation:

A primary service of the medical program is provision of consultation to staff, to physicians, clinics, and other health facilities, and to community agencies. The medical staff truly forms part of the total habilitation team at the Center and are readily available to discuss problems of individual students. This is also facilitated by close contact with treatment agencies to monitor medication and alter treatment according to functioning in the Center. This procedure brings staff, Center, and treatment agencies all closer together.

IX. Physical Therapy Program:

Physical Therapy functions through scheduled individual treatment sessions, group sessions, or through more informal activities within the classroom. Each child's needs are carefully assessed and an individual program is established. Emphasis is given to proper seating in the classroom and lunchroom, proper use of wheelchairs, walkers, and other equipment, and improving ambulation. Close coordination is maintained with all staff in working toward short and long-range objectives.

X. Occupational Therapy:

Similar procedures are followed in occupational therapy. Both group and classroom programs are followed to develop fine motor skills and improve perceptual deficits. Feeding is given special emphasis in the lunchroom and self care skills are stressed in each class. A future outgrowth of this program will be development of occupational skills activities at all levels leading to formal pre-vocational and early vocational training.

XI. Training:

All medical and therapy activities have a training component for the Center is viewed as a multipurpose educational resource for students and professionals alike. Medical students at all levels and graduate house staff from Cornell University Medical Center regularly observe and participate in screening conferences. A fellow in Pediatric Habilitation from Cornell is regularly part of the medical staff, responsible for medical examinations and consultation. Nurses from Cornell and the Skidmore College School of Nursing are scheduled at regular intervals. Physical therapy students from the Hunter College School of Health Sciences have a weekly teaching session and a program for occupational therapy students at New York University and Columbia University is being planned.

XI. Training:

By these means it is hoped to interest more health personnel in the handicapped child and especially to prepare them to participate in the multi-disciplinary approach to the child with developmental deficits.

XII. Research:

Clearly, the Center has considerable potential for studies of methods and results of habilitation programs for the multiple handicapped child. By carefully developing records and follow-up on each child a beginning has already been made in the major tack of developmental research.

Studies are currently under way of siblings with muscular dystrophy and of children with congenital rubella. These efforts will increasingly gain in depth and extent as the data develop. Ultimately of course, the research component will take on major proportions as long term follow-up of "graduates" and their ultimate functioning in society is assessed.

ALS:rw
Encl.

OBJECTIVES, PROCEDURES, AND USES OF THE CMHC EDUCATIONAL EVALUATION DESIGN

Sylvia Walker

Since the inception of Special Education there has been an urgent search for evaluation techniques and instruments designed to meet the needs of the handicapped. For many years many conscientious professional workers have been disenchanted with the prevailing modes of arriving at decisions about the exceptional student. On too many occasions the traditional manner and means of judging capacity and achievement have culminated in dead end diagnostic labeling.

Limitations encountered in the evaluation of the handicapped child are particularly acute in the appraisal and measurement of the multiple-handicapped. All too often (as a result of difficulties in eliciting responses), the multiple-handicapped student is categorized as "untestable". Thus, these children are often deemed "untestable" because of their inability to work independently, inadequate gross or fine motor movement, emotional instabilit[illegible]/or limited language ability.

In order to meet the educational and habilitative needs of students at the Center for Multiple-Handicapped Children, a comprehensive, interdisciplinary evaluation is used. Emphasis is placed on the actual functioning of the child rather than the application of vague diagnostic labels. As a result of the cooperative evaluation endeavor of the following staff members: physician, nurse, classroom teacher, psychologist, social worker, guidance counselor, occupational, physical and speech therapists, a child being considered for admission to the Center receives a fairly extensive diagnostic workup.

In an effort to resolve many of the problems involved in the educational assessment of the multiple-handicapped child, teachers at the Center (actually, during the initial planning stage of the Center) created an educational evaluation instrument specifically designed to overcome many of the shortcomings of existing tests.

The objectives of the Educational Evaluation are the following:

1. To determine whether the candidate being evaluated is indeed a multiple-handicapped child who would benefit from placement at the Center.

2. To pinpoint the functional level of the child, and to draw some tentative educational implications in planning an appropriate remediation program for the child that will maximize physical, emotional, social and intellectual growth.

3. To provide baseline data and to become part of the child's permanent educational profile.

4. To facilitate future educational planning both at the Center and in subsequent educational settings.

To meet the challenges of the above objectives the Educational Evaluation has been designed as a flexible instrument which may be used with children from pre-school to young adult levels, who, because of a combination of handicapping conditions exhibit a wide range of learning and behavioral problems. For example; an obvious adaptation is required when testing a deaf, cerebral palsied child. Instead of relying on an oral response to test items, the examiner would communicate with the child through gestures. Another example; since visually handicapped children rely more on tactile input, a greater use is made of concrete testing materials than printed stimuli. Many responses may be arrived at through simulated games. Areas assessed by the test include; communication skills, language usage, self-awareness, cognitive abilities, perceptual skills, motor ability and social functioning. The examiner is asked to include in the summary report the level of achievement of the child in the areas of reading and math specifically and more generally in other areas.

The evaluation is usually administered on a one-to-one basis. In instances where it is deemed necessary, a parent may remain with the child throughout the examination procedure. Aside from the formal test, provision is also made for observation of the child's interaction with peers.

The test may be administered wholly or in part within the classroom setting, depending on the distractibility of the child. The child's reaction to the entire examination situation may be as significant as the actual responses to the test items. Therefore, teacher observation is important throughout the test.

The Educational Evaluation has three major sections.

1. Examiner's manual - contains instructions and materials developed by teachers at the Center.
2. Examiner's Record Sheets - used to record specific information relating to each section of the test.

   The summary sheet of this section contains a synopsis of the child's functioning in various areas and recommendation for placement.
3. Student Worksheets - contains child's responses to test items.

There is no set time allotment for test items. Children are encouraged to perform at their optimum level. Teachers are encouraged to use supplemental materials during the test such as puzzles, toys, peg boards, books, blocks and form boards to elicit responses.

A decision regarding admission to the program is made at a full screening conference at which all staff members who have participated in the evaluation of the child discuss their findings. The decision is based on a consensus of the screening team. Where there is doubt about admitting the child to the Center, the rule of thumb has always been to offer the child this additional opportunity to be served. In cases where it is determined that a child is not a suitable candidate for the Center, recommendations for a more appropriate educational setting are offered to the referral agency.

It should be noted that this full screening process is both time consuming and costly. Where possible, a preliminary paper screening is conducted in order to facilitate efficient use of screening time.

We have found our intake procedure very satisfactory in enabling the Center to obtain a population that is likely to profit from the program.

CENTER FOR MULTIPLE-HANDICAPPED CHILDREN
105 E. 106 Street
New York, N.Y. 10029

EDUCATIONAL EVALUATION

Name________________________________

Address______________________________

Date of Birth__________________________

Date of Evaluation______________________

Evaluator____________________________

COMMUNICATION SKILLS

I. LANGUAGE COMPREHENSION

A. Listening

1. Audio acuity____

2. Ability to answer questions or follow directions____________

____

B. Vocabulary Comprehension

____

____

REMARKS: Language Comprehension______________________

____

____

II. LANGUAGE USAGE

A. Oral Expression

1. Intelligible speech____________________________

2. Vocabulary___________________________________

3. Sentence structure____________________________

B. Written Expression

1. Ability to write a sentence______________________

2. Form and structure____________________________

3. Handwriting__________________________________

4. Spelling_____________________________________

REMARKS: LANGUAGE USAGE___________________________

____

____

READINESS

I. SELF-AWARENESS

A. Knows Name

1. Can identify name ________________________________

2. Can copy name ________________________________

3. Can write name ________________________________

B. Knows Age ________________________________

C. Knows Sex ________________________________

D. Knows Home Address/Borough ________________________________

E. Draws Picture of Self ________________________________

____

F. Identifies Parts of Body ________________________________

____

REMARKS: Self-Awareness ________________________________

____

II. RESPONSE TO DIRECTORS

A. Imitates gestures ________________________________

B. Follows instructions and commands ________________________________

____

III. NUMBER KNOWLEDGE

A. Counting

1. Rote ________________________________

2. Rational ________________________________

B. Number Groups

1. Recognizes groups ________________________________

2. Names groups ________________________________

C. Writing Numerals ________________________________

READINESS (cont'd)

IV. COLOR KNOWLEDGE

A. Identifies colors________________________________

B. Names colors________________________________

V. VOCABULARY

A. Knowledge and understanding of:

1. Names of objects________________________________

2. Concepts of time/space/quality, etc.________________________________

____

B. Usage ________________________________

____

VI. OTHER AREAS

A. Identifies same/ different________________________________

B. Completes picture or shape________________________________

C. Copies picture or shape________________________________

D. Matches pictures________________________________

E. Puts pictures in sequential order________________________________

F. Completes puzzles________________________________

G. Use of materials (Cutting, pasting, arranging, etc.)________________________________

____

H. Other:________________________________

____

GENERAL COMMENTS: Readiness Test________________________________

____

____

READING

1. MECHANICS

A. Left to Right Progression

B. Eye Span

C. Turning Pages Right to Left

D. Keeping Place (without marker)

E. Reading Orally and Silently

F. Names of Letters of Alphabet

G. Sounds of Letters

REMARKS: Mechanics

II. READING FOR COMPREHENSION

A. Matching

B. Sequence

C. Content Comprehension and Interpretation

D. Oral Reading

REMARKS: Reading for Comprehension

III. WORD RECOGNITION

IV. READING LEVEL (approx.)

MATHEMATICS

I. ROTE COUNTING ____________________

II. RATIONAL COUNTING ____________________

III. NUMBER WRITING ____________________

IV. NUMBER VALUE ____________________

____

V. TIME CONCEPTS ____________________

____

VI. MONEY CONCEPTS ____________________

____

VII. MEASUREMENT ____________________

____

VIII. GEOMETRIC SHAPES ____________________

____

IX. FRACTIONAL PARTS ____________________

____

X. SKILL WITH NUMBER PROCESSES ____________________

____

____________________ WRA Level: ______

XI. MENTAL PROBLEM-SOLVING ABILITY ____________________

REMARKS: MATHEMATICS ____________________

____

BEHAVIORAL CHARACTERISTICS

CHILD'S PRESENTING BEHAVIOR(e.g., friendly, withdrawn hostile, independent, bizarre, aggressive, cooperative, acting out, hyperactive, inappropriate)

AS OBSERVED WITH:

TEACHER____

____

PARENTS____

____

PEERS____

____

OTHER____

____

REMARKS: Behavioral Characteristics (Including any unusual physical manifestation, e.g., drooling, grimacing, tremor)

____

____

____

Name________________________________

Address_____________________________

Date of Birth_______________________

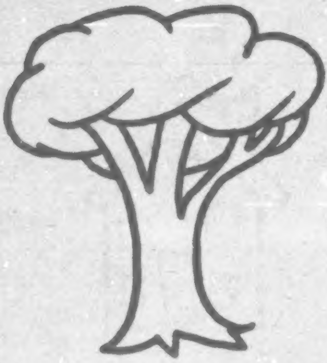
Date of Test________________________

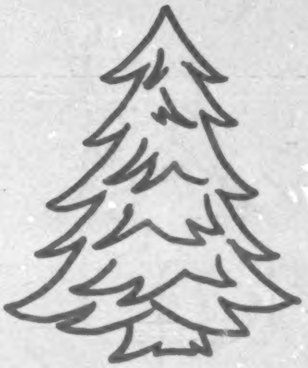
Evaluator___________________________

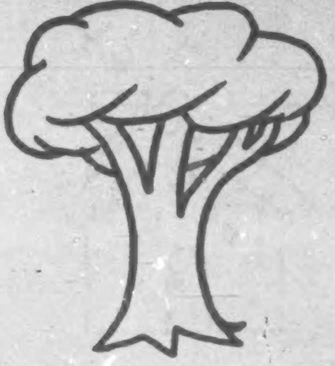
CENTER FOR MULTIPLE-HANDICAPPED CHILDREN
105 E. 106 Street
New York, N.Y. 10029

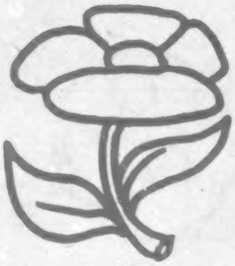
EDUCATIONAL EVALUATION

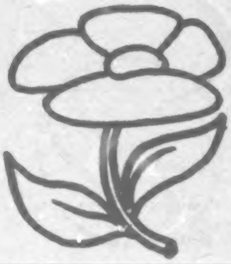
SUMMARY AND RECOMMENDATIONS:

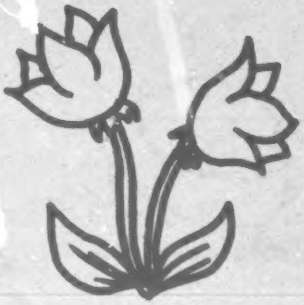


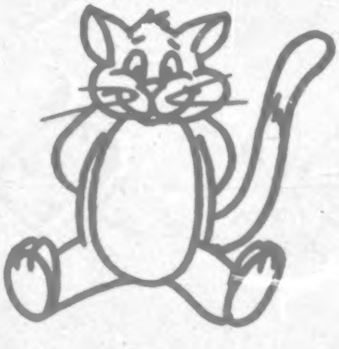


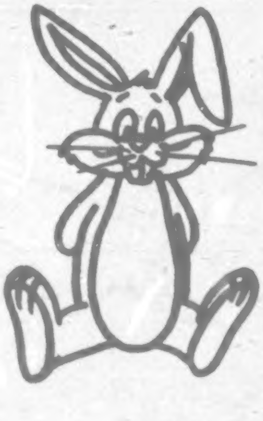


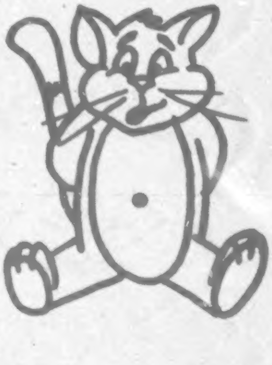


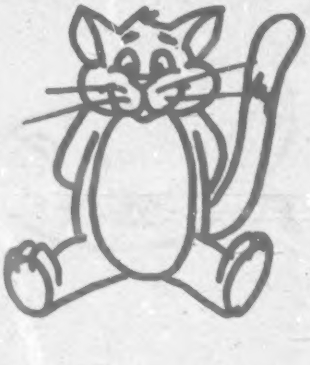


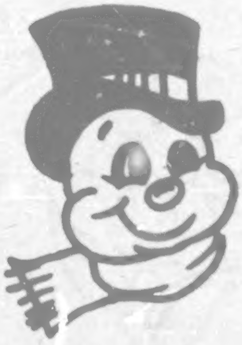


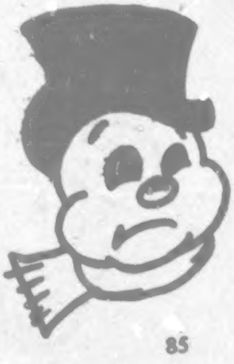


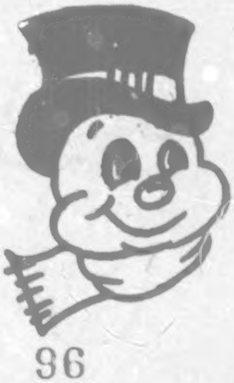


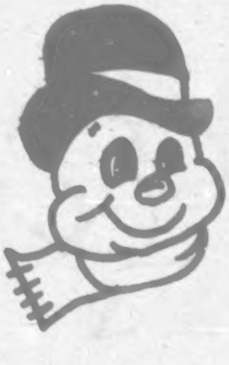


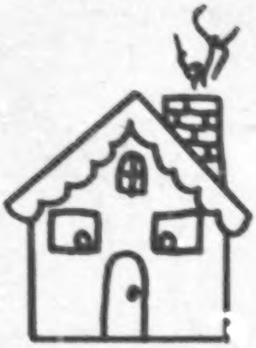
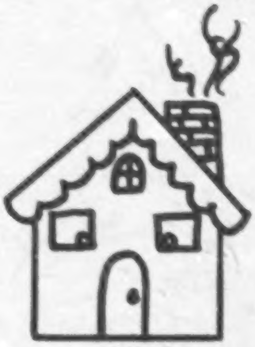
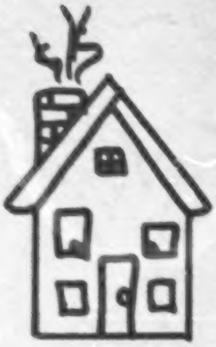


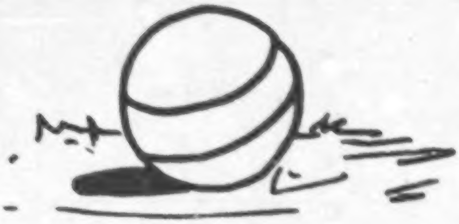
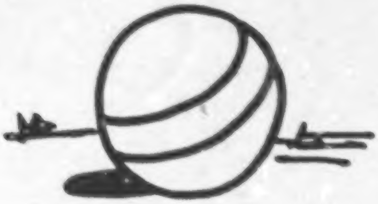
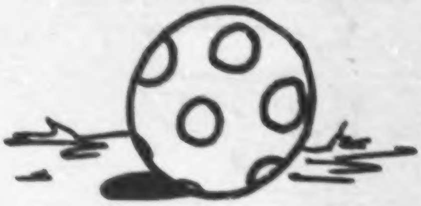


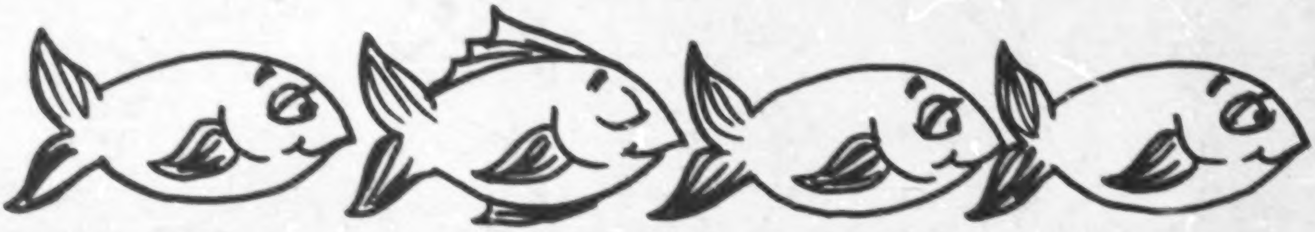


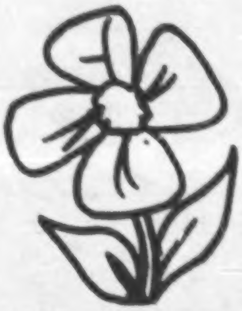
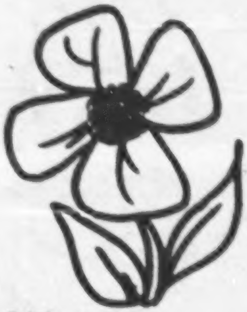
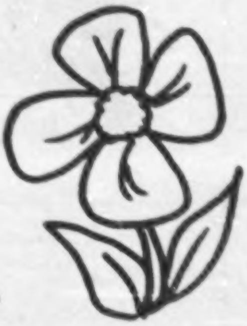
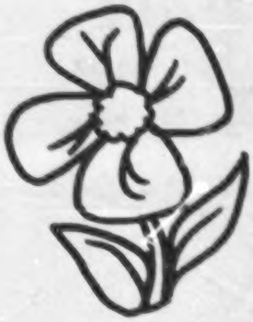


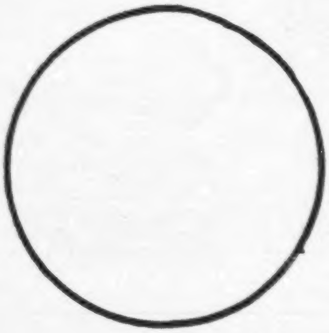


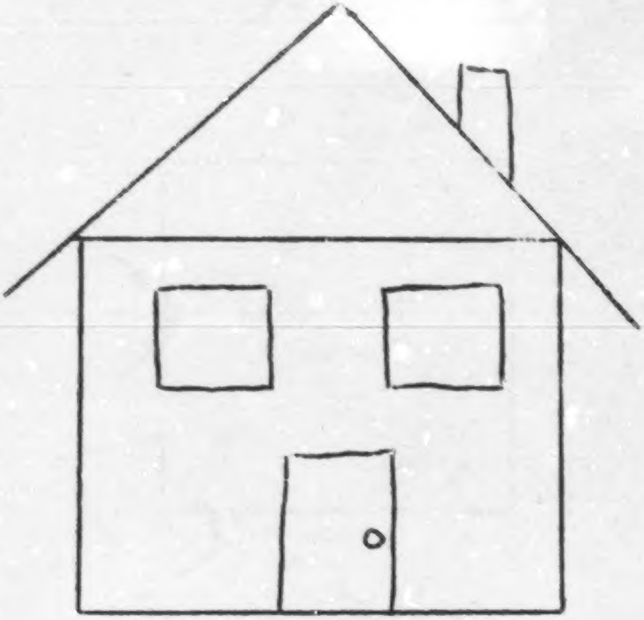




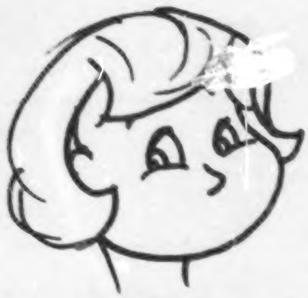




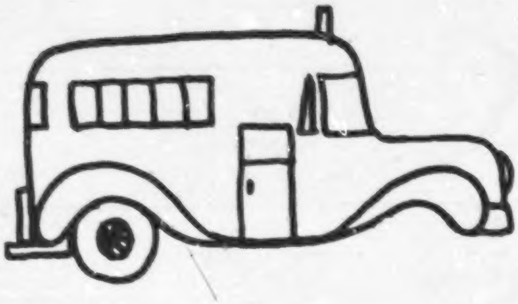


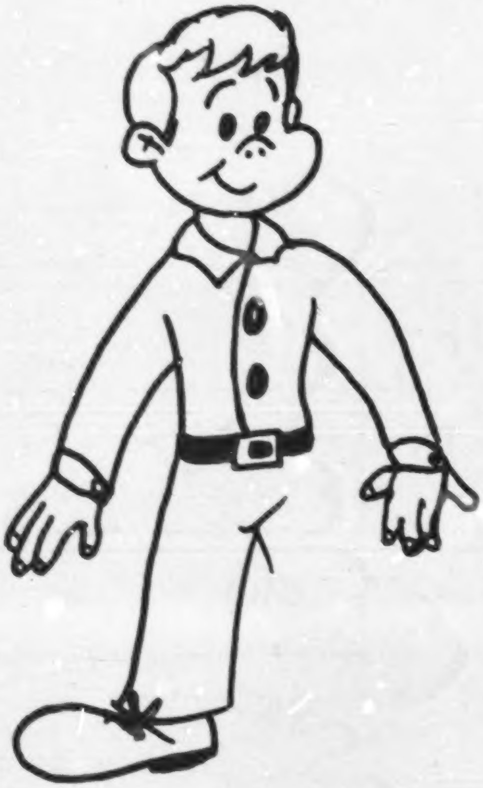















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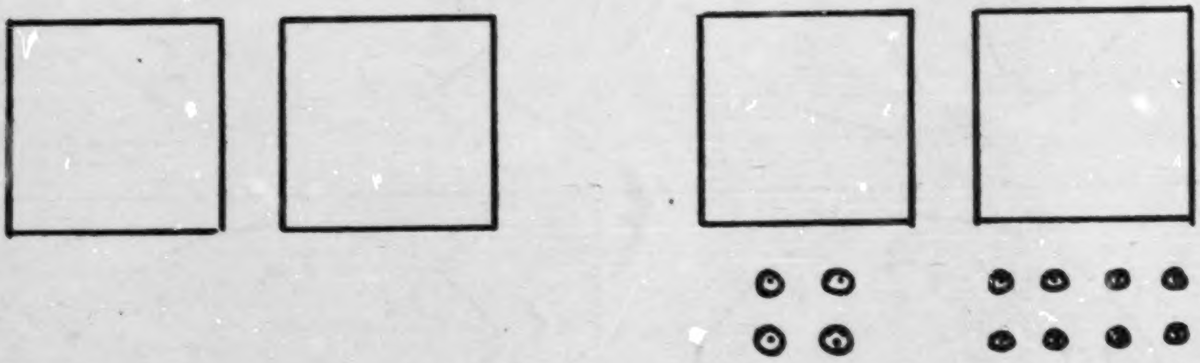

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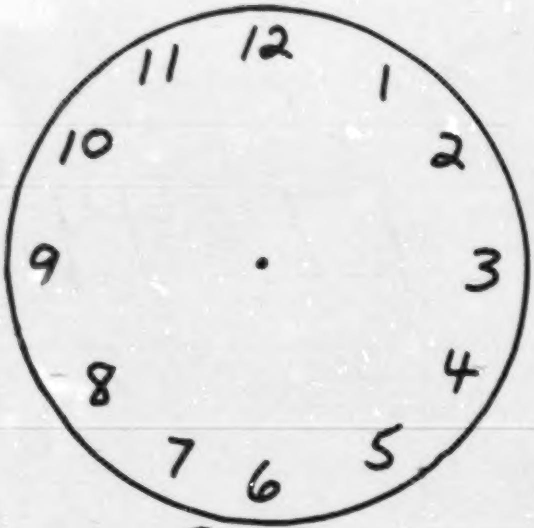
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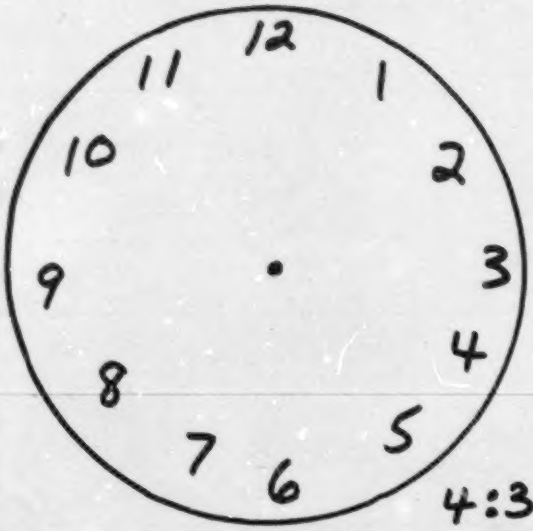
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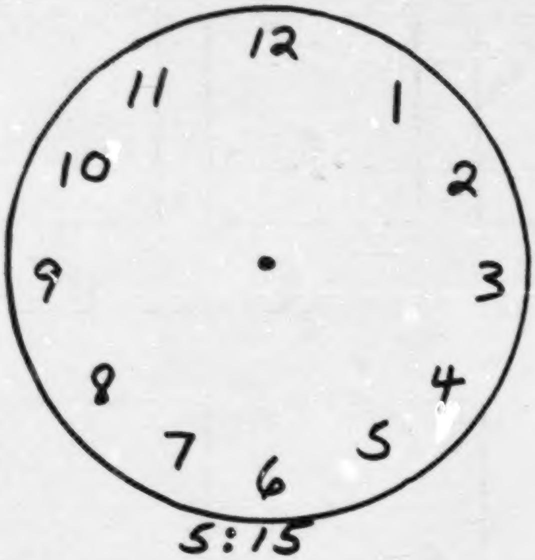
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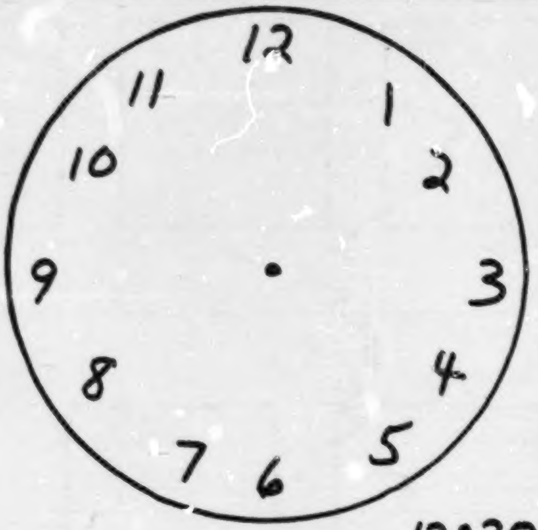
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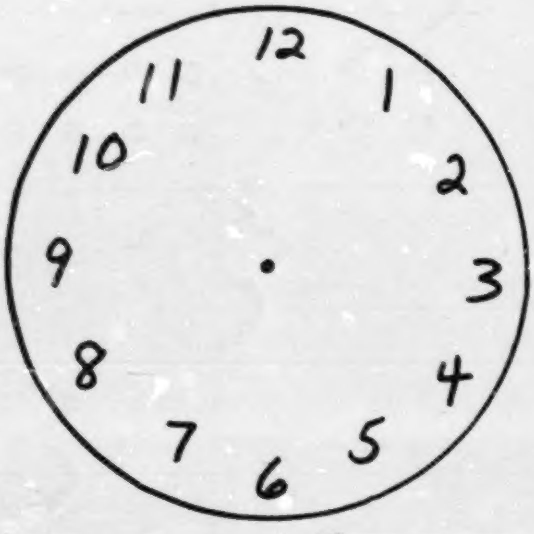
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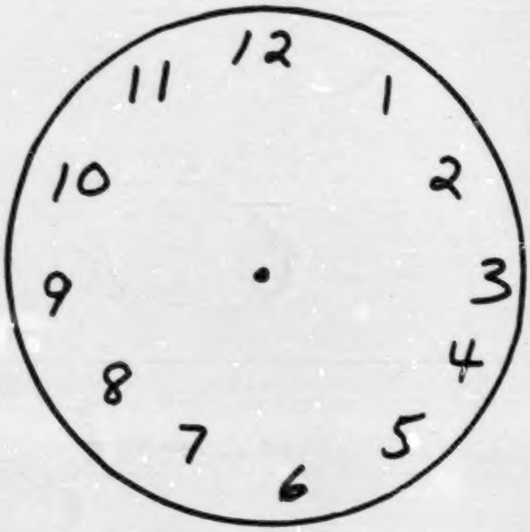
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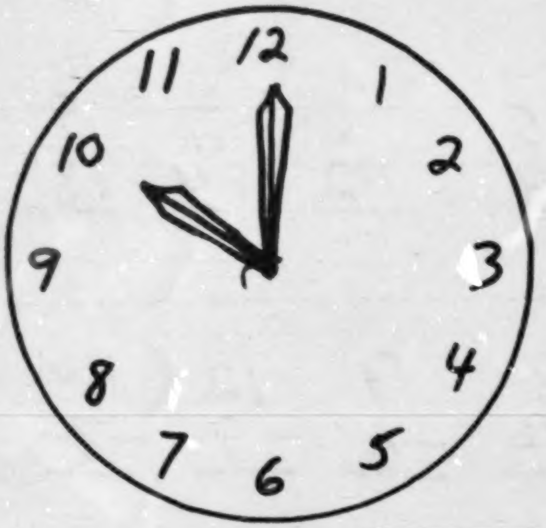
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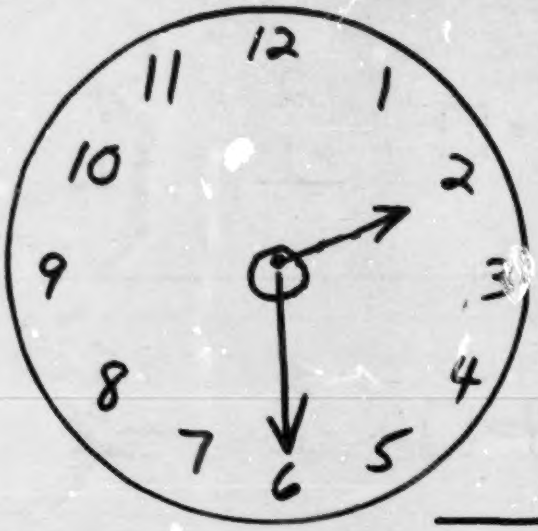
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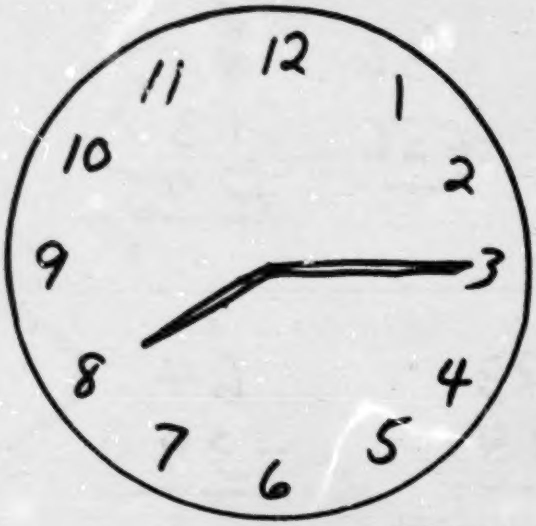
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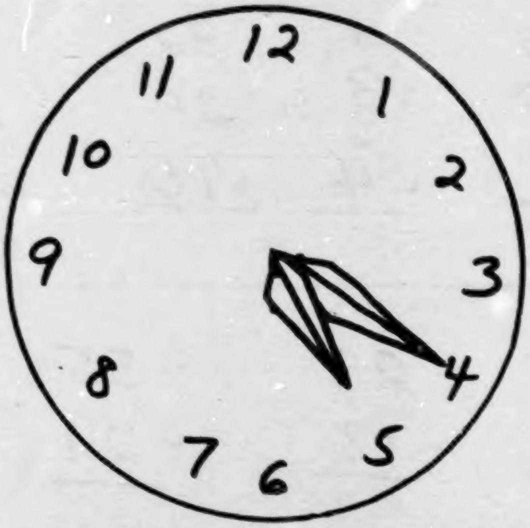
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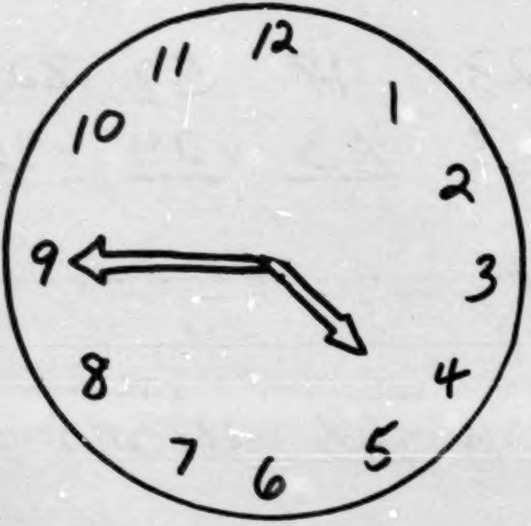
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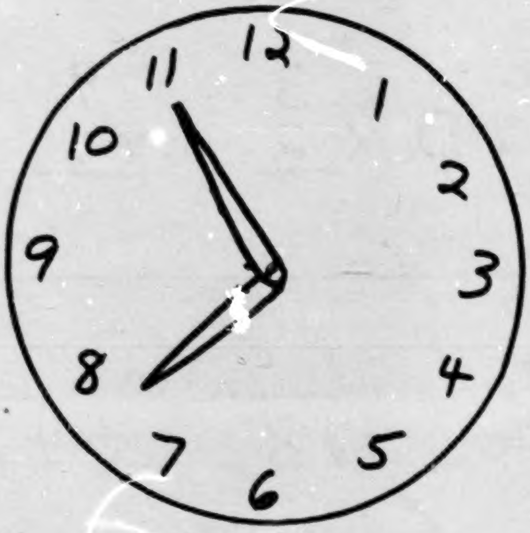
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$1+1=\square$ $\quad \begin{array}{r} 2 \\ +1 \\ \hline \end{array} \quad \begin{array}{r} 4 \\ +1 \\ \hline \end{array} \quad \begin{array}{r} 5 \\ +4 \\ \hline \end{array} \quad \begin{array}{r} 6 \\ +2 \\ \hline \end{array} \quad \begin{array}{r} 7 \\ +4 \\ \hline \end{array} \quad \begin{array}{r} 9 \\ +8 \\ \hline \end{array}$

$4-1=\square$ $\quad \begin{array}{r} 3 \\ -1 \\ \hline \end{array} \quad \begin{array}{r} 5 \\ -3 \\ \hline \end{array} \quad \begin{array}{r} 8 \\ -4 \\ \hline \end{array} \quad \begin{array}{r} 9 \\ -6 \\ \hline \end{array} \quad \begin{array}{r} 12 \\ -9 \\ \hline \end{array} \quad \begin{array}{r} 14 \\ -8 \\ \hline \end{array}$

$\begin{array}{r} 3 \\ 2 \\ +1 \\ \hline \end{array} \quad \begin{array}{r} 1 \\ 3 \\ 6 \\ +4 \\ \hline \end{array} \quad \begin{array}{r} 32 \\ 24 \\ +40 \\ \hline \end{array} \quad \begin{array}{r} 75 \\ +8 \\ \hline \end{array} \quad \begin{array}{r} 36 \\ +56 \\ \hline \end{array} \quad \begin{array}{r} 452 \\ 137 \\ +245 \\ \hline \end{array}$

$\begin{array}{r} 29 \\ -18 \\ \hline \end{array} \quad \begin{array}{r} 55 \\ -21 \\ \hline \end{array} \quad \begin{array}{r} 23 \\ -14 \\ \hline \end{array} \quad \begin{array}{r} 64 \\ -39 \\ \hline \end{array}$

$4\times2=\square$ $\quad \begin{array}{r} 3 \\ \times 2 \\ \hline \end{array} \quad \begin{array}{r} 9 \\ \times 7 \\ \hline \end{array} \quad \begin{array}{r} 23 \\ \times 3 \\ \hline \end{array} \quad \begin{array}{r} 48 \\ \times 3 \\ \hline \end{array} \quad \begin{array}{r} 53 \\ \times 24 \\ \hline \end{array} \quad \begin{array}{r} 823 \\ \times 96 \\ \hline \end{array}$

$6\div2=\square$ $\quad 4\overline{)8} \quad 5\overline{)75} \quad 6\overline{)968} \quad 27\overline{)384}$

$$\begin{array}{r} 62.04 \\ +\ 5.30 \\ \hline \end{array} \qquad \begin{array}{r} 7.96 \\ -3.09 \\ \hline \end{array} \qquad \begin{array}{r} 1.5 \\ \times\ 3 \\ \hline \end{array}$$

$\frac{1}{3} \div \frac{1}{3} = \square$ $\frac{15}{5} = \square$ $\frac{7}{9} - \frac{5}{9} = \square$ $1\frac{3}{4} = \frac{}{4}$

$$\begin{array}{r} 4\frac{5}{6} \\ 3\frac{1}{3} \\ +2\frac{1}{2} \\ \hline \end{array} \qquad \begin{array}{r} 5 \\ -1\frac{1}{3} \\ \hline \end{array}$$

$4\frac{1}{5} \times 3\frac{1}{3} = \square$

$\frac{3}{10} \div \frac{3}{4} = \square$

$\frac{8}{9} \times \frac{9}{4} \times \frac{1}{2} = \square$

$\frac{2}{3} = \frac{}{12}$

WRITE AS A DECIMAL

$\frac{2}{3} =$ ____

20% of $120 = \square$

$\frac{2}{3}$ of $35 = \square$

WRITE AS A PERCENT

$\frac{3}{4} = \square$

$\frac{1}{2}$ yd. = $\square$ IN.

$1\frac{1}{2}$ hr. = $\square$ MIN.

$2\frac{1}{3}$ doz. = $\square$

$\frac{3}{4}$ yr. = $\square$ mos.

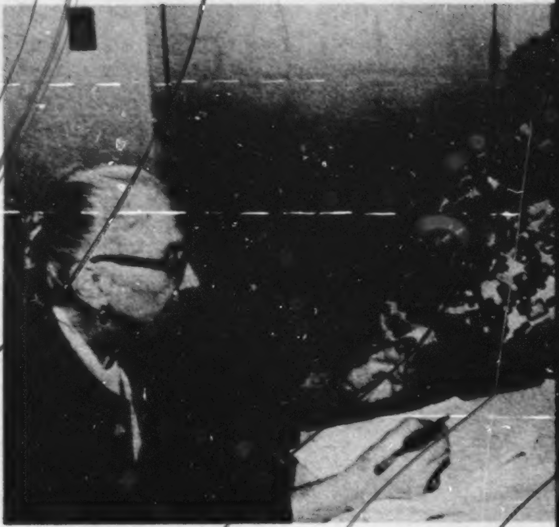
CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

keep
your
teeth
clean?
visit
your
dentist?

The health needs of each child are given careful attention by our medical director.

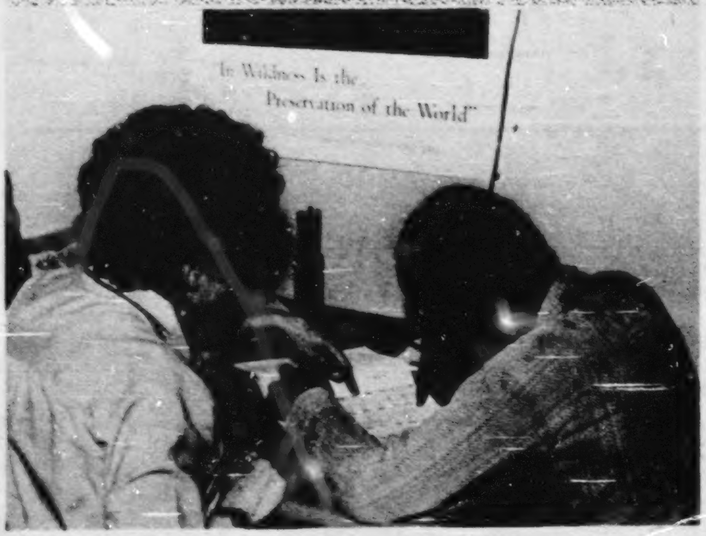
Las necesidades individuales de salud de cada niño, recibe la esmerada atención de nuestro director médico.

visit
your
dentist?
eat
good
food?



Interviews by social workers and guidance counselor provide initial and on-going case-work services to children and parents.

Entrevistas hechas por nuestros consejeros y trabajadores sociales proveen las formas para los servicios iniciales y actuales necesarios para el niño y sus padres.


"In Wildness Is the
Preservation of the World"

Psychological testing helps to define each child's emotional, social and educational needs.

Pruebas sicológicas ayudan a definir las necesidades emocionales, sociales y educativas de cada niño.

FROM INOCULATIONS TO SOCIAL SECURITY NUMBERS

Ida Goldman - School Secretary

I consider it a privilege to be a member of a staff dedicated to working with special children.

The position of secretary in special education requires total involvement. One must have an awareness of the effects of handicapping conditions on the children, and be empathetic toward the parents. We shall try to clarify some of the outstanding aspects of the position in "regular" schools. While there is, without question, a good deal of overlapping, the items chosen are particularly relevant to this setting.

Because the Center for Multiple-Handicapped Children was an innovative program and is a relative newcomer to the education scene, it has been in the limelight and is a veritable "fishbowl". The secretary must be aware of the importance of an atmosphere of cordiality and warmth toward our many visitors. When we moved into our school facility, it was felt that community relations would play a vital role, and visits were made to the local post office, police precinct, nearby hospital, neighborhood bank, stores, and public schools. As we are located in a complex of buildings housing many public service programs, we made sure to establish contact with all of these close neighbors.

Every school district has its own regulations. In New York City such regulations are governed by the State Education Laws, the By-Laws of the Board of Education of the City of New York and by current contractual obligations. School secretaries have some knowledge of what the job entails from the licensing requirements set by the Board of Examiners, but the real learning takes place on the job.

With regard to personnel, the Center differs from many "regular" schools in a number of ways. Our pedagogical staff includes, in addition to teachers and supervisors, personnel from the Bureau of Child Guidance and from the Bureau of Speech Improvement. The stenographic and clerical staff are part of the Civil Service Administrative Personnel as are the staff nurse and the therapists. For paraprofessional and school lunchroom personnel, it is necessary that the school secretary become familiar with still other regulations.

When the program started it was federally reimbursed and we had to learn a whole new set of symbols and language--OD14, OP330, OBA151, Imprest Funds, RPO, REM, etc. When the program proved itself and was placed on tax-levy funds, it became necessary to learn another jargon which involved such matters as C.A.R., salary credit, differentials, promotionals, non-attendance, Jarema credit, tenure, pension, maternity leaves, military leaves, sabbatical leaves, terminal leaves, "leaves in lieu of", resignations, retirements, PCCN, Vacancy Form, salary fixations, course requirements, change-of-address form, requisitions, change-orders, non-list items, and Bureau of Supply items. Still another language is involved with Pupil Accounting: Attendance and Register forms, 209A and B, Pupil Surveys, Transportation Reports, cumulative record cards, articulation cards, class cards, alphabet cards, change of register slips, emergency cards, health records, test forms. Naturally, many of the standard procedures did not fit our facility so revisions were necessary.

The registration of the children differs from the neighborhood-school practice. We serve children from the five boroughs, and they are transported by Board of Education contracted buses and vans. After notification by the Bureau of Transportation that bus arrangements have been completed, the parent is advised of the date and time of pick-up. The parent is asked to come into the school on the day the child is admitted to register the youngster. The parent is given a copy of the school calendar and the Center's regulations concerning her child are explained. At registration, the secretary asks the parent to complete an emergency card, and to sign a consent slip for class trips and permission to photograph the child.

Information is given to the new parent about the Parents Association. Often, the telephone number of another parent who lives close by is offered to facilitate carpool arrangements or merely to provide company when school meetings or Parents Association meetings are held. The president of the Parents Association is given the name and address of each new entrant.

Should a youngster require emergency treatment, upon instruction from the Medical Director or the Staff Nurse, the secretary telephones the nearby hospital to alert the medical staff that a child is being brought over. The parent is called and informed about her youngster. Utmost tact is exercised so as not to unduly worry the parent.

Class trips require more attention than in a regular school... even for a walk around the block. The secretary maintains a notebook on her desk to which she has attached a checklist of reminders for teacher's review. Is there adequate help? Does any child require an identification tag? Will the nurse be seeking the child for medication at a scheduled time? Will the child miss a therapy session? Will the class return in time for lunch?

Photograph consent forms are important. Newspaper photographers and television crewmen often photograph the pupils. Our Center has been included in many documentary films. It is essential. therefore, that a record of parental consents be available.

It is most gratifying to see the development of the children. The shy child who would not tell his name at the time of registration gleefully comes into the office on an errand; the girl who has considerable difficulty learning how to read has learned to recognize her name by seeing it daily on the attendance sheet which she brings to the office; the child who may have some difficulty communicating with her peers is a marvelous interpreter for the secretary. The "Times" is delivered to staff members by willing newsboys and girls; messages and administrative bulletins are circulated accurately and punctuated by a hug and a kiss. The excitement generated at birthday parties and the flurry of exchanged invitations and greeting cards show tremendous social maturation.

The office staff is always willing to lend a helping hand to those children who are eager to learn some clerical skills and who want to be office monitors. Education is the business at the Center and education is not necessarily confined to classrooms. The general office serves as a classroom.

One of the morning rituals is particularly beautiful and illustrates poignantly the interest shown. About ten very young children must wait to be escorted to another school facility upstairs. As they wait, one of the secretaries very thoughtfully starts their day off sweetly--with a lollipop!

Another "different from regular schools" item is the fact that the Center serves children from ages five to seventeen. Our assignment, therefore, runs the gamut from recording innoculations to dealing with social security numbers and working papers. It's interesting and challenging.

Many of the pupils have "graduated" to other facilities. They may graduate but they sure do gravitate--right back to the Center. These alumni are very proud when they sign the V.I.P. Visitors Book. One such visit by two students recently was to celebrate their former teacher's birthday. Not only did they remember her birthday but they remembered to bring presents, cake and soda for the entire class.

This stream of thoughts, starting as a trickle has turned into a river of kaleidoscopic impressions. It is hoped that other school secretaries see through the all-absorbing, quite demanding job to the rewards that make it all worthwhile.

THE ROLE OF THE PARAPROFESSIONAL AT THE CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

Aida Guadalupe

I have always been interested in working with children with multiple-handicaps. When my child was sent to Blythedale Hospital where there are children with many handicaps, I saw how teachers and paraprofessionals were able to help these children function in their daily activities. Finally, I got the opportunity to help when a friend got me a para-professional position at the Center for Multiple-Handicapped Children. To be able to assist these children of all ages and grade levels is a beautiful and challenging experience. One works with these children in reading, arithmetic, spelling, arts and crafts, and music. They are taught to work with different machines like the Language Master, to work in groups, play games together, to speak, and to dress and groom themselves.

My relationship with the children is good. You get to understand them as they learn to understand you, and one gets to identify their particular needs.

A paraprofessional is also assigned to do clerical duties at the office in the Center. We operate the duplicating machine, the audio-visual machines, prepare work for the children, work in the library, stock room, and we help to develop functional bulletin boards.

Some paraprofessionals go to college and study courses that will enable them to help themselves on the job at the Center. My relationship with the teacher is very good. We understand each other and we prepare the children's work together. We aim to get the children prepared for the future and even with their handicaps these children could have an exciting future. All the paraprofessionals get along nicely.

We share our ideas and help each other if we should have questions. The community and parents of these children are very pleased with the job which the Center is doing. Knowing that there are people who care for children who are unable to help themselves makes these parents feel secure that their children are getting the special help and attention otherwise not given to them in the regular public schools. Many children were not able to attend school before the Center was established.

ASSEMBLIES

Robert McDonald and Sylvia Walker

Marc became an Eskimo. It was the parka that did it. The soft fur lining stroked his arms as he slipped them into the sleeves. The hood shot way out over his forehead shading his eyes against the glare of ice and snow. He still had to squint and make his eyes small to keep out the blinding light. Maybe that's why his face would get so wrinkled and lined even before he was 40. Marc would have to squint for hours at a time to see the white polar bear's black nose hidden behind his giant paw.

Miss Catherine Barry of the Museum of Natural History helped Marc out of the Eskimo jacket and eased him gently back to earth giving him another artifact to handle and examine at leisure. His other classmates slipped in and out of the parka becoming Eskimoes in their turn. When the short hour had passed, Miss Barry would pack up her furs and ivory carvings and leave the classroom as quietly as she had come. But each child would have a permanent built-in feeling of what an Eskimo is and how he lives to carry around with him for the rest of his life.

No one will disagree with the fact that educational experiences must be appropriate to the needs of those for whom they are designed. Planning experiences for the multiple-handicapped is especially challenging, since these children represent the full range of intelligence and they labor under an equally broad spectrum of handicaps through which this intelligence must filter and function. In short, the need to expand the experiences of the multiple-handicapped child in order to make them as encompassing as possible, cannot be over-emphasized. A small assembly with no child hidden and each able to participate, a sort of theater-in-the-round, or a living theater, where actors and audience can exchange roles, where there is no remoteness, no one hanging from the rafters or the chandeliers with the separating miles of silence that intimidates and reduces one to passivity - a small assembly seems just the thing wherein to catch awareness on the wing.

"Funga, alatheya, ashay, ashay...Funga, alatheya, ashay, ashay..." The drums rolled out their cry of "welcome", as the dancers turned in the small open space a few feet in front of Tommy, Hanan, and Heriberto. The spinning feet, shaking hips and sinuous arms operated like the struck tine of a tuning fork and set Michael and Marc in motion dancing in their seats. The walls of the small cafeteria had vibrated in harmony and in dissonance to many kinds of beats, mainly to the beating of small hands and voices out of tune with themselves and the world around them. But, today, something primal from the tall rain forests of Nigeria, something from the wild, exuberant, and young voice of the early Yoruba shook the walls and vibrated in the air and entered into minds and hearts usually closed and guarded against the intrusion of 20th century, civilized sound. What many learned voices had often failed to do. The young dancers and singers of the La Roque Bay School of Dance had done quite simply. "... tomorrow, to fresh woods and pastures new".

The search for educational relevance for the multiple-handicapped child must employ a total approach which leads to multi-sensory imput. Aside from the use of multi-media and adapted materials and equipment in the classroom, we at the Center for Multiple-Handicapped Children rely heavily on community resources to provide enrichment. In addition to local talent finding its way to expression in the form of shows and entertainments and parties, we have played host to puppet theaters, musicians, firemen, policemen, telephonemen, and on and on. After a short course in special education they each found a way to display their wares before our critical audience. As Sandy Robbins of the Shadow Box Theater put it recently: "These kids give as good as they get."

Sylvia Walker
Bob McDonald

A STUDENT TEACHER AT THE CENTER

Fran Katzel - Hunter College

As my student teaching internship is over at the Center for Multiple-Handicapped Children, I can't help but think of the valuable and rewarding experience I have shared with the children and staff. I can vividly remember my first day at the Center.

Having little experience in special education, I walked into the Center with feelings of anxiety and enthusiasm. I wondered to myself, "what would the multiply handicapped child be like" and "how would we react to each other". As I walked around the school for the very first time, I found myself saying that the children aren't pretty; a reaction I didn't want to have, and one that I have to admit I was soon ashamed of.

It was a bit strange to me how children with so many handicaps, which made them attend a special school, all looked so happy. There wasn't a child that passed the other student teachers and myself that didn't react to Dr. Schulps as he showed us around the school. Each child gave a smile, a hug, or a word or two of greeting and was greeted back responsively and warmly. It was quickly clear to me that the Center was a warm place and was sure to have an environment conducive to academic and emotional-social growth.

Throughout my student teaching days, I found the classes to vary greatly in the age and handicaps of the students, yet all to be similar in providing for the individual needs of their students. The teachers are attuned to their students as well as the competent clinical staff. All personnel seem to work well together, always with the best interests of the children in mind.

After working a very short time, the handicaps of the children seem to disappear as each child is valued for what he can do and is then taught the next step desired. The children are reached through multiapproaches. They are taught body awareness and self concept through puppetry, creative expression through dance and movement, motor development through gym and physical therapy, speech and language development through therapy and music, and pride in class and self through presentations, shows, and personal responsibilities.

I found working with the children to be frustrating, exhilarating, tedious, and rewarding. Each step a child takes is important, as is appropriately encouraged and supported.

I will never forget the experiences I had at the Center; the boy who only knew how to hit me and talk nasty, who now smiles and hugs me; the deaf girl who smiled and vocalized sounds as I played the guitar for her class; the children that I taught and learned from; the smiles, the hugs, the love from the children, the talks with the children and staff. Most of all I'll remember how the children helped and cared for each other and how many steps of advancement were taken in the short time I was at the Center.

My days at the Center have filled me with great desire to offer my knowledge, my guidance, my help and my love to these children. I was indeed wrong when on my first day I said that the children are not pretty. The fact is, the children are beautiful.

Fran Katzel

TAXONOMIC INSTRUCTION AT THE CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

Kathleen George - Elaine Rosenbluth

As part of the establishment of the Center for Multiple-Handicapped Children we were charged with being innovative, not just for the sake of innovation, but to seek approaches that might be profitable for our population. We had heard that an experiment had been conducted in Taxonomic Teaching at two schools for emotionally disturbed children in New York City. In order to probe more deeply into the facts we arranged a meeting with Dr. Abraham J. Tannenbaum and his staff at Teachers College - Columbia University. Dr. Tannenbaum felt that Taxonomic Instruction was adaptable for use with a multiple-handicapped population. Four classes representing a cross section of the population were chosen to participate in the experiment and it was installed very shortly after the Center was opened.

In retrospect we feel that it might have been better to have waited a year or so because there were so many difficulties encountered in the "settling in" process that proper attention could not be given to what was basically, a rather comprehensive system of instruction. Nevertheless, there were many gains derived from our early experimentation in Taxonomic Teaching. Aside from providing a framework and pattern of organization a number of consultants and assistants became actively involved with the installation of the program at the Center. It is difficult to assess, statistically, the contributions made by these additional personnel, but there is little doubt that it was quite substantial. Over the succeeding two years, we were able to proceed with greater understanding in the utilization of a taxonomic instruction for our population. We do believe that the modifications and adaptations conceived by all of the involved personnel have provided an approach that is indeed both innovative and fruitful.

Candidates for the Center are carefully screened, so that only those children are admitted for whom a satisfactory program does not exist. Strict procedures are followed in the processing of psychological, medical, and neurological records. Children are accepted from age five through seventeen. Children are examined by all the disciplines at the Center and a consensus at the evaluation conference determines eligibility.

After months of preparation the Center opened with a part of its quota of 128 children and thirteen of its quota of twenty-one special education teachers and three teachers of speech improvement. It continues to screen children and admits them to the program as soon as vacancies occur. There are now sixteen classes with a maximum of eight children in a class. Elaine F. Rosenbluth, as Taxonomy Coordinator, directs her attention specifically to four classes in order to help diagnose and clarify the reading problems and weaknesses of the children. She also assists in the selection of materials which meet individual needs.

Until recently the Taxonomy of Instructional Treatments was a model for the teaching of reading only. However, at the Center for Multiple-Handicapped Children, the Taxonomy is being applied to children who have not reached the developmental or academic levels necessary for reading instruction. Instead, attention has been devoted to the creation of a taxonomy that addresses itself to a series of non-academic tasks. For example, child G., a severely disturbed 13 year old girl who was born without hands, refused to participate in academic tasks. Therefore, initial instruction was limited to teaching her how to use her prosthetic devices (hooks) most effectively. Tasks included inserting a key in a lock to open a locked door, dialing telephone numbers, baking cookies, catching and throwing variously sized balls. After a while a slow gradation of more academically oriented tasks was employed until G. became fully capable of pursuing a substantial academic program.

The Center has also used the Taxonomy as a reading model. This model consists of seven variables of which the first three Basic Skills, Basic Subskills and Sequential Levels are addressed to the content of reading. These components are labelled the "What" of Instruction and can be determined by the child's performance on standardized reading tests. The four remaining variables of the Taxonomy are labelled the "How" of Instruction and consist of the Instructional Setting, Instructional Mode, Communication (or Sensory Modality) Input and Communication (or Sensory Modality) Output. The reader is referred to the Chart and Glossary found at the conclusion of this article for clarification of this terminology. In planning instruction for children who are already reading or who are ready to begin reading, all seven variables are used. In planning instruction for children who are not ready for reading, the four variables of the "How" of Instruction are used and the reading content of the Taxonomy is replaced by reading readiness content or any other content that will ultimately culminate in the child's preparedness for reading instruction. An examination of the "How" of Instruction reveals that the Taxonomy is a classification system in which all of the options available to the teacher during the instructional act are enumerated for each of the four dimensions to which the Taxonomy is addressed: Instructional Setting, Instructional Mode, Communication (or Sensory Modality) Input, Communication (or Sensory Modality) Output. By using the data contained in the child's case history, and supplementing this information with data gathered by detailed, recorded observations of the child's behavior during the school day, instruction can be planned to facilitate transmission of the content by judicious selection of the options listed under the four taxonomic dimensions. For instance: It was ascertained from the case history data and the teacher's observation that for child R. a small group setting was more beneficial than a large group setting, that a game of chance, was more effective as motivation than any of the options available to the teacher under Instructional Mode, that R's auditory channel of sensory modality input was more intact and functional than any of the other sensory channels, and that R. because of grave speech difficulties expressed himself most adequately through gestures and symbolic marking. The teacher, therefore, has made a judicious selection at the initial stage of instruction. It is expected that such a selection will facilitate the transmission and reception of information when coupled with appropriate content presented at a non-frustration level. One might then expect to achieve the much desired optimal pupil engagement.

Up to this point the taxonomic instruction that has been discussed is referred to as individualization of instruction and is based on the hypothesis that there is at least one preferential wavelength through which information can be most efficiently transmitted to the pupil. Central to taxonomic theory and practice is a corollary hypothesis which assumes that a positive correlation exists between pupil involvement (engagement) and academic achievement. Once a child's attention has been captured and focused on academic tasks, there will be a consequent increase in learning skills which will be observable and measurable, attention being considered in taxonomic theory as the most basic of all learning skills.

The second phase of taxonomic instruction is called personalization of instructional treatment. The pupil usually comes to the special school with an inadequate ability to receive and transmit information and a limited background in reading content and reading skills. Nevertheless, one may seek and find some degree of pupil abilities in these areas. The quantity and quality of the pupil strengths are established through testing, recording and observations. For the multiple handicapped population there exists a different ratio of strengths to weaknesses than exists in other less seriously involved populations. Personalization of instruction seeks to enlarge the child's strengths and to restrict his weaknesses. This process requires the selection of one option from each of those entries listed under Instructional Setting, Instructional Mode, Communication (or Sensory Modality) Input and Communication (or Sensory Modality) Output. Thus, there are actually a total of four choices to be made. One of the four choices will constitute a less preferential or less than optimal wavelength which will result in pupil disengagement. The degree and type of disengagement is recorded for the ongoing process of decision making in planning instruction for the child. The same decision making process is used to select the four components in personalization as in individualization of instruction, but in personalizing the short-term objectives are different. The objective is to reduce tensions, and, ultimately, through regulated exposure to these stressful instructional situations to desensitive the child to his vulnerabilities. By alternating individualization and personalization of instructional treatment for the child, it is anticipated that there will be developed an ability to cope with both types of learning situations.

The Taxonomy of Instructional Treatments is the paradigm by which individualization and personalization of instruction are achieved. In an operational sense, the use of Taxonomy (as a decision-making tool in individualizing and personalizing instruction) applies to the teacher as well as the child. Both principals in the instructional act, the teacher and the pupil, bring to the situation habituated styles of transmitting and receiving information. The use of the Taxomomy should effect greater awareness in the teacher of his own style in communicating to and with pupils. It is expected that the teacher will demonstrate greater flexibility of style by giving full exposure to that which is often at the intuitive and subconscious levels of instruction.

To illustrate the implementation of the Taxonomy in planning instruction for children, a multiple-handicapped child, a frail eleven year old boy, S., will be used as the subject. His case history, teacher observations, and anecdotal record will be included in order to demonstrate how this information is used to individualize and personalize instructional treatment for S.

This child was rated dull-normal having achieved an I.Q. of 84, Leiter I.P.S., 3/71 with a somewhat higher potential. The validity of this rating is questionable in the light of his present level of performance. S. was a rubella baby and suffered severe sight and hearing loss. His record indicates seven cataract operations in addition to heart surgery. He attends the New York Lighthouse for socialization one day per week after school. His articulation is poor. This can be attributed more to poor speech habits than to his handicaps. The record further indicates that he is hyperactive, highly emotional, an incessant talker, easily frustrated and very insecure.

S. is the eldest of three children. He has a younger brother 7 years of age and a sister two years of age, both non-handicapped. His mother shows great concern for his welfare and progress. In spite of her many duties she extends herself in order to supply all of his physical and medical needs. She states that at home S. is very difficult, that he requires an inordinate amount of attention, that he is at times hostile and aggressive toward the siblings, and can be stubborn and explosive. It can be assumed that the home environment, with three active children, would hardly be soothing to a highly distractible boy. According to his mother, "There's hardly ever a quiet spot in the house."

The following teacher observations of the day-by-day activities of S. at the Center tend to indicate that he accepts his disabilities and has the potential for making maximum use of his many strengths. At present he is functioning academically on a high third grade level, and can exercise self-control, good reasoning, and sound judgement. He has maturity and displays a lively interest in his surroundings, the passage of time, and current events. He is conscious of being the most advanced of his group scholastically, and he considers himself the 'leader'. The following incidents also demonstrate some of his capabilities:

1. He enjoys jigsaw puzzles and has declared himself the champion. A puzzle of moderate difficulty was done by him, without help, in a short space of time. Another, 500 pieces, and difficult enough to intimidate the average adult, was tackled by him, successfully, and with single-minded concentration, for long periods of time. At one point while working on it he leaned over, too far, and spilled the entire puzzle on the floor undoing the work of days. Instead of being devastated by this he reassured everyone that "It's just an accident. It will take a little time, but I can fix it again." He immediately sat down on the floor and began to reinsert the pieces in their places with the same patience that he had shown before. He had to be persuaded to return the puzzle to his desk where he could work in comfort.

2. He enjoys operating machines, and can handle the minute details involved with patience and skill. He has taken responsibility for setting up the dictaphone and language master for his own benefit as well as for the group when needed. Noteworthy is the oddity of his behavior in using his vision when he is listening to an auditory stimulating machine such as the dictaphone. He brings his head down to the level of the machine in order to watch it, when all that is necessary is for him to station himself at an appropriate distance from the machine in order to hear it. This is evidence of S.'s intense reliance on the visual stimuli and his inadequate use of the auditory channel which in this case is more intact than his vision.

The brief anecdotal record below typifies the current pattern of behavior: In this instance efforts were being made to get him to settle down and work on his assignment for the morning.

9:15 A.M. S. is riding a wagon. He will not get out his work. He takes the wagon to the wrong place.
9:20 A.M. S. is playing with the shelf. He is screaming and banging on the shelf. He is trying to grab a sheet of paper from my hand.
9:30 A.M. S. is banging a chair. He says his throat is dry and insists on getting a drink of water.
9:40 A.M. S. begins to complain about his eyes. He rubs his eyes insisting that they hurt. He inspects his glasses then replaces them after stating that they hurt his nose.
9:44 A.M. S. begins to read.
9:50 A.M. S. stops to stretch, look around, play with the pencil, talk.
9:55 A.M. S. reads. He does it poorly and is made to repeat lesson.
10:15 A.M. S. does Arithmetic (Oral and Written drill).

This regressive behavior manifests itself in hostility, high distractibility, extreme stubborness, and occasionally, flights from reality. He becomes obsessed with the TV set (again a machanical operation). He becomes preoccupied with the pipes under the sink in the room, and states that he is "checking them." He considers no one an ally, and regards every attempt at persuasion as an effort to "push him around". However, there is always an indication that he is aware of his inappropriate behavior but helpless to prevent it. After a particularly distressing session he is very apologetic, and will make a remark, such as, "I have a very hot brain".

In analysing the data, certain facets of S's learning style became apparent and were used to individualize instruction for the child. Pertinent to the selection of an option for instructional setting was S's lack of interaction with his peers. Therefore the instructional task was placed either in a one-to-one setting with the teacher (option #4) or in a student self-instruction context (option #2). It was believed that these settings would generate the least amount of tension for S. Of particular relevance for the selection of the instructional format option was S's interest in games--particularly jigsaw puzzles. Therefore, option #1 under Instruction Format was selected in planning individualized instruction. Since S. demonstrated great reliance on his visual channel of input, option #1 (vision) was the first to be selected for S's treatment. The nature of the jigsaw puzzle task neccessitated the selection of option 2 (Motoric Response--gestures and movement) to complete instructional treatment. Thus, 2 1 4 5 represents a numerical description of S's first instructional task--a non-reading task chosen primarily to engage S in an unstressful learning situation in which there are inherent spatial relationships and cognitive processes to be learned.

In S's case, personalization of instruction merely required setting aside of the jigsaw puzzle and the inclusion of reading content. With this, tension was immediately generated in S's behavior. As a rule the tension is manifested by complaints that his "eyes hurt", that he "is thirsty", that he "wants to ride the wagon". S. tries many things in order to prevent the beginning of the task. Once the task is initiated, the teacher's prodding is required to maintain S's attention.

Therefore, there is a need to change the Instructional Setting option from #2 to #4-- Teacher-Student; Instructional Mode has been restricted to option #3-- Test-Response; Sensory Modality Input remained primarily option #1 Visual; while option #1-- Vocal-Reading out loud, was chosen in Sensory Modality Output. Thus 4 3 1 1 was the first personalized treatment to be used for S.

Although the period has of necessity been brief, application of the "How" strategies detailed above to individualize activities of this pupil have resulted in the following observed behavior changes:

1. The Teacher-Student Setting provided support when needed. Through teacher's use of leading questions and demonstration S. began to discover, with a good deal of satisfaction, that he could figure out answers to his own questions. A development of positive attitudes is expected to result in a gradual reduction in the period of time required to settle down and purposefully apply himself to his work.

2. The Test-Response Instructional Mode was used in developing the Basic Skill of Language Analysis and the Basic Subskill-Word Structures on a Sequential Level-Grade 3. (See The "What" of Instruction) Since S. was very insecure about approaching new or unknown words the aim was to develop his word attack skills. Here it was found that his greatest need was self-confidence and there was already indication of positive change in this direction.

3. Since S. is still dependent to a great degree on sight as a sensory medium the Visual Sensory Modality Input is being used with all activities. In the near future cassettes will be brought into daily use so that his love of machinery will become a motivation toward greater involvement of auditory inputs such as 2 4 6 or 7.

4. The Vocal Response has proved valuable for S. because of his need for oral drill to improve poor articulation and generally careless speech patterns. Involvement with the various activities and a growing interest in his work have resulted in lengthening periods of concentration, so that is has become possible for the teacher to remove herself from the Teacher-Student setting without causing a break in the continuity of S's work. Behavior changes have also been created through extension of this individualized treatment to his interest in a moderately difficult jigsaw puzzle, the airplane. He was asked to write a story about the completed puzzle. This extension changed three options in the treatment. Instructional Setting remained option #2--Student Self-Instruction; Instructional Mode became option #1. Exploration; Communication (or Sensory Modality) Input was #6--Visual Kinesthetic and Communication (or Sensory Modality) Output became #2-- Motoric Response--marking and writing. (see the Comprehensive Strategy I.) With the selection of different options no additional tensions were observed by the teacher. Therefore, this treatment can also be considered part of S's individualized reservoir.

Again, with change of Instructional setting to option #4- Teacher-Student, he has been working with a Student Teacher whose aim is to develop his ability to do independent work. S. is given daily written assignments each consisting of a series of exercises in the areas of language analysis, and arithmetic. S. completes the exercises, makes his own corrections, and rates his performance, after checking the results. Then a final rating is given by the teacher. Some tension was observed initially. S. required reassurance and help with certain items before he could complete the assignment. After three sessions he was able to complete an assignment on his own. Here the Instructional setting is option #2; Instructional Format is Option #4; Sensory Modality Input is option #4/ Sensory Modality Output-option #4. In the foregoing description of the decision making process in selection options for S. there is evidence that the expected desensitization to certain of his disabilities is taking place. It is hoped that the continued use of the Taxonomy for individualization and personalization of instruction will effect even profounder changes in S's learning behavior.

Finally, the efforts of the Taxonomy specialists have always been characterized by a realistic but compassionate view of each child's prospects for survival. Their collaboration with the teachers has been complete and dedicated. Therefore, one can assume, with some certainty, that Taxonomy will make a significant contribution to the future success of the Center.

APPENDIX A

COMPREHENSIVE TAXONOMY MODEL

The 'How' of Instruction

COMPREHENSIVE TAXONOMY

STRATEGY

Instructional Setting	Instructional Mode	Communication Input	Communication Output
1. Teacher-Total Class	1. Exploration	1. Visual	1. Oral Response
2. Student Self-Instruction	2. Problem Solving (Divergent)	2. Auditory-Visual	2. Motoric Response (marking and/or Writing)
3. Teacher-Subgroup	3. Testing Recall	3. Auditory	3. No Response
4. Teacher-Student	4. Problem Solving (Convergent)	4. Motoric (Haptic, Tactile, Kinesthetic)	4. Oral-Motoric (Marking and/or Writing)
5. Student-Student Parallel	5. Exposition	5. Auditory-Motoric	5. Motoric Response (Gestures and/or Movement)
6. Student-Total Class	6. Game Competition Standard	6. Visual-Motoric	6. Oral-Motoric Response (Gestures and/or Movement)
7. Student-Subgroup	7. Game Competition Player	7. Auditory-Visual-Motoric	
8. Student-Student Tutorial	8. Game Competition Field		
9. Student Self-Directed	9. Game Competition Team		
10. Student-Student Interactive	10. Role Playing		
11. Group Self-Instruction	11. Programmed Response		
12. Group Self-Directed	12. Patterning		

OPERATIVE TAXONOMY-Strategies found to be most often used by teachers in the classroom.

Instructional Setting	Instructional Mode	Communication Input	Communication Output
1. Teacher-Total Class	1. Exploration	1. Visual	1. Oral Response
2. Student Self-Instruction	2. Problem Solving (Divergent)	2. Auditory-Visual	2. Motoric Response (Making and/or Writing)
3. Teacher-Subgroup	3. Testing-Recall	3. Auditory	3. No Response
4. Teacher-Student	4. Problem Solving (Convergent)		4. Oral-Motoric (Marking and/or Writing)
5. Student-Student Parallel	5. Exposition		

Child's Name________________ Lesson #________________ Date________________

Teacher's Name________________ Instructional Site________________

THE WHAT OF INSTRUCTION

Basic Skills	Basic Subskills
1. Cognitive-Perceptual	1. Symbolic Discrimination 2. Memory Span 3. Directionality-Laterality 4. Time Relationships 5. Space Relationships
2. Language Analysis	1. Consonants 2. Vowels 3. Sight Vocabulary 4. Word Structure 5. Syntax
3. Comprehension	1. Main Ideas 2. Details 3. Sequence-Relationships 4. Word Meaning 5. Context Inference 6. Critical Analysis 7. Recreational Reading
4. Study Skills	1. Skimming 2. Dictionary 3. References and Texts 4. Maps, Graphs & Tables 5. Speed & Accuracy 6. Other Sources & Processes
5. Aesthetic Expression	1. Perception 2. Interpretation 3. Creation

Sequential Levels

1. Grades 2 and Below
2. Grades 2 - 4
3. Grades 4 - 6
4. Grades 6 and Above
5. Ungradable
6. Multilevel

Appendix A Research and Demonstration Center, Teachers College

GLOSSARY OF TAXONOMY MODEL TERMS

I. Basic Skills

1. Cognitive-Perceptual:- Primary conceptual and perceptual functions such as understanding sequential time relationships or discriminating basic shapes. These skills are considered prerequisites for the acquisition of the other basic reading skills - language analysis, comprehension and study skills.

2. Language Analysis:- Language elements from minimal to large units, and the synthesis of those units into meaningful contexts.

3. Comprehension: - The understanding and interpretation of what is read.

4. Study Skills: - Those tools which are taught by the teacher and used by the child to facilitate self-instruction and which are prerequisite for higher level independent inquiry.

II. Basic Subskills

1. Cognitive-Perceptual:

    1. Symbolic Discrimination: - Discrimination and labeling of objects, shapes and letters; the objects, shapes and letters can be concretely or pictorially represented.

    2. Memory Span: - Retaining and retrieving units of information.

    3. Directionality-Laterality: - Left/right orientation of body schema and visual perception and the establishment of one-sided motor preferences.

    4. Time Relationships: - Sequencing of actions or events in the order of their occurrence.

    5. Space Relationships: - Locating objects in space and the use of concepts such as over, under, in, on, etc.

2. Language Analysis

    1. Alphabet: - The mechanical manipulation of the alphabet letters and the association of the letters with graphic symbols, ignoring the phonic elements involved in sounding.

    2. Consonants: - To label and sound consonants and to use this skill in decoding words.

II. Basic Subskills (con't)

2. Language Analysis (con't)

   3. Vowels: - To label and sound vowels and use this skill in decoding words.

   4. Word Decoding: - To make integrative use of consonant and vowel sounds for the purpose of reading words.

   5. Sight Vocabulary: - To read words without extended analysis. Sight vocabulary is a reservoir of known words.

   6. Word Structure: - To recognize lawful and unlawful letter sequences in words and meaningful parts of words (roots, suffixes, prefixes) that can be combined to create more extended language units on the word level.

   7. Syntax: - To use grammatical structure or word order patterns in sentences and phrases.

3. Comprehension

   1. Main Ideas: - Identification of central ideas in paragraphs and stories.

   2. Details: - Selection of specific information from sentences, paragraphs and stories.

   3. Sequence Relationships: - Recalling and organizing in sequential order specific details of sentences, paragraphs, and stories.

   4. Labeling: - To offer several applicable labels for an object or activity.

   5. Word Meaning (Independent of Context): - Defining isolated words.

   6. Word Meaning (in Context): - To select out of several possible meanings the one meaning appropriate to a word in a particular context.

   7. Content Inference: - To infer the meaning of a sentence, paragraph and story when the meaning is not explicit.

   8. Critical Analysis: - The evaluation of information, ideas and opinions contained in reading materials or discussions.

   9. Recreational Reading: - Reading for pleasure. Recreational reading carries the added component of being a means by which reading skills are practiced and expanded.

II. Basic Subskills (con't)

4. Study Skills

   1. Skimming: - Scanning reading materials to gain either an overall impression of the content or specific information within the content.

   2. Dictionary: - The location and pronunciation of words, syllabication, stress and diacritical marks, syntax and selection of appropriate word meaning from a list of definitions.

   3. References and Texts: - The use of indices, chapter headings, subheadings and bibliographies of reference books and texts for the purpose of locating information.

   4. Maps, Graphs and Tables: - The reading and construction of maps, graphs and tables.

   5. Speed and Accuracy: - The acceleration of reading speed without a concomitant loss in comprehension.

   6. Library: - The use of library resources, e.g., audiovisual equipment, books, catalogues, journals, etc.

III. Sequential Levels

1. Readiness: - The instructional range for reading that encompasses reading skills up to and including the first grade.

2. Primary: - Includes second and third grade reading skills.

3. Intermediate: - Encompasses fourth through sixth grade reading skills.

4. Upper: - Encompasses reading skills in the seventh and eighth grades.

5. Multilevel: - A range of grade levels in which the total class membership can participate regardless of the children's functional reading levels.

IV. Instructional Setting

1. Teacher-Total Class: - A prescribed grouping of students in attendance that day involving task interaction between teacher and students.

2. Student Self-Instruction: - A student working alone on an instructional task that is teacher-initiated and prescribed.

3. Teacher-Subgroup: - Less than the total number of students in attendance that day being involved in a teacher-prescribed task that requires task interaction between the teacher and students (excluding teacher-student).

IV. Instructional Setting (con't)

4. Teacher-Student: - A one-to-one instructional interaction between the teacher and the student.

5. Student-Student Parallel: - Two students working in close proximity on teacher-prescribed tasks, possibly sharing material or equipment with no physical or verbal interaction between the students intended.

6. Student-Total Class: - A student is assigned to instruct all attending class members in a teacher-prescribed task.

7. Student-Subgroup: - A student is assigned to instruct less than the total number of attending class members in a teacher-prescribed task.

8. Student-Student (Tutorial): - A two-student grouping based on an inequality of skills in which the more skilled student functions as tutor to the less skilled one.

9. Student Self-Directed: - A student, with teacher approval, working alone on a self-initiated and self-prescribed instructional task.

10. Student-Student Interactive: - Two students working on a teacher-prescribed task involving the sharing of material or equipment and requiring either social or task-oriented interaction between them.

11. Group Self-Instruction: - At least three students cooperatively involved in a group-initiated and prescribed task.

12. Group Self-Directed: - At least three students cooperatively involved in a group-initiated and prescribed task that has the teacher's approval.

V. Instructional Mode

1. Exploration: - Involves an open-ended task that does not necessarily culminate in a product.

2. Problem Solving (Divergent): - Involves discrimination of relevant and irrelevant data and manipulation of relevant data in order to reach an indefinite set of responses.

3. Testing Recall: - Involves the student's ability to retrieve facts either immediately or after a lapse of time.

4. Problem Solving (Convergent): - Involves discrimination of relevant and irrelevant data and manipulation of relevant data in order to reach a predetermined set of responses.

5. Exposition: - Involves the teacher, or a student, as the central figure in transmitting instructional content to an essentially passive audience.

V. Instructional Mode (con't)

6. Game Competition, Standard: - Requires striving by the participant (s) to meet a performance standard that is imposed by any of the following: the teacher, the nature of the game itself, or the participant's inherent competitiveness.

7. Game Competition, Player: - Requires two participants to compete with each other to be the winner of the activity.

8. Game Competition, Field: - Requires the participants to strive against a field of others, all of whom are seeking to be the only winner in the game.

9. Game Competition, Team: - Requires that the participants be divided into teams, each team becoming the unit of competition that seeks to be the winner of the activity.

10. Role Playing: - Involves play acting in which the content and the assumption of roles can be either preplanned or spontaneous.

11. Programmed Response: - Involves extensive exposition, small sequential learning steps and immediate student feedback.

12. Patterning: - Involves the teacher, or a student, as the central figure in transmitting instructional content (verbal or nonverbal) to an audience that replicates the content immediately.

VI. Communication Input

1. Visual: - Reception of instructional stimuli through the sense of sight.

2. Auditory-Visual: - Reception of instructional stimuli through the senses of hearing and sight.

3. Auditory: - Reception of instructional stimuli through the sense of hearing.

4. Motoric (Haptic, Tactile, Kinesthetic): - Reception of instructional stimuli through the sense of touch in the palm (haptic), or fingers (tactile), or through the sense of movement and tension in muscles, joints and tendons (kinesthetic).

5. Auditory-Motoric: - Reception of instructional stimuli through the senses of hearing and touch (haptic, tactile) or internal body movement (kinesthetic).

6. Visual Motoric: - Reception of instructional stimuli through the senses of sight, touch (haptic, tactile) or internal body movement (kinesthetic).

7. Auditory-Visual Motoric: - Reception of instructional stimuli through the senses of hearing, sight, and touch (haptic, tactile) or internal body movement (kinesthetic).

VII. Communication Output

1. Oral Response: - Vocal expression in reaction to instructional stimulus.
2. Motoric Response (Marking and/or Writing): - Marking or written expression in reaction to instructional stimulus.
3. No Response: - No overt expression in reaction to instructional stimulus.
4. Oral-Motoric (Marking and/or Writing):- A combined vocal and motoric (marking or writing) expression in reaction to instructional stimulus.
5. Motoric Response (Gestures and/or Movement): - Gestures or movement in reaction to instructional stimulus.
6. Oral-Motoric Response (Gestures and/or Movement): - A combined vocal and motoric (gestures or movement) expression in reaction to instructional stimulus.

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A REVIEW OF SOME READING MATERIALS USED AT THE CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

Rona Willen

The Center for Multiple-Handicapped Children, in Manhattan, is a Center which was developed for those children who could not function in existing settings in the public school system. The children are meeting with success, and many of them have "graduated" and gone on to those very settings which were unfeasible such a short time ago.

Reading is one of the areas where these children have met with failure in the past. Yet many have begun to read. To discover why and how this has happened, a survey has been made of many of the classes at the Center to see what materials are used, why they were chosen, and how (or if) they have been adapted by the teacher. The following is a systematic, class by class description and analysis of reading materials used by some of the teachers at the Center for Multiple-Handicapped Children.

Mrs. R. has a group of children ranging in age from approximately eleven through thirteen. There is a variety of materials and equipment being used in her class. One of the first shown to me was the Language Master, which each child used for many action words, basic concepts, words from the child's reader, and additional material related to the reading book, such as consonant blends. Each child can work the Language Master independently. This is valuable, as the child is receiving reinforcement and the teacher is free to work with other children. Each child in this class has a reader and workbook which is used on an individual basis. In addition, three of the children use Scott-Foresman's Splendid Journey as a supplement, but also more for interaction for skills like keeping place, sitting as a group, waiting one's turn, etc. The teacher also uses the Weekly Reader Series with the whole group. This serves to reinforce the above-mentioned skills. Mrs. R. employs the real experiences of the children as an added reading experience. Experience Charts based on events that have occurred are very meaningful and relevant for the class. Sesame Street and Electric Company are on every morning. The children all get a chance to watch parts of it. While some are working, some are watching television. Mrs. R. feels the reinforcement is good. Certain children watch it more than others because the level at which they are functioning makes it more relevant for them. The children also have an independent activity of watching film strips accompanied by a record. These are usually fairy tales or science films.

At the end, the child gets oral or written questions on the film. For those children who cannot read very well, the story is just listened to. Again, this is still an independent, reinforcing activity.

The children also use the typewriter as another input device for reviewing words. The teacher finds this an effective method since the children enjoy using the machine. Bingo games are used a great deal. The children have to say and spell the word. For those who cannot read, matching the words enables them to participate and learn.

Other games, such as Look, by Dolch, and Grab, a teacher-made game, also enable the children to interact on an independent level at the same time that they are reinforcing their learning. As I sat in Mrs. R's room, several of the children, upon finishing breakfast, took the Grab game, and started playing. They did this of their own volition, and were extremely cooperative with each other. They really seemed to enjoyed it.

In addition to the Bank Street Series for individualized work, and the Scott-Foresman for group work, Mrs. R. uses the Peabody Rebus program for those children in her class who are non-readers, for those who are hard of hearing, and for those who have not succeeded with anything else. She finds this program quite successful. Another aspect of the reading program is a notebook for vocabulary that is kept by each child. Vocabulary words are recorded each day with the date. Missed words are reviewed daily.

Mrs. R. also has a quiet, listening corner where each child can retreat every day with a tape recorder, tape, and book. These are from the Library of Congress. The children listen to the story as they follow along in the book.

One observation made by Mrs. R. is that the kinesthetic approach is a valuable aid in learning words. Bouncing a ball, for example, while spelling a word, seems to be helpful. Mrs. R. finds that games using a bouncing ball help to retain sequence and recall.

When I questioned Mrs. R. as to which program or method she preferred, she told me that there was no one specific program superior to another. The program and method used merely depends upon the needs of the child, and whether those needs are being met.

Miss D. has a class of eight year old primarily deaf children as a result of Rubella Syndrome. The program she uses can only be applied to six of her children. The other two are unable to participate; one is deaf-blind, and the other is autistic. The program that Miss D. uses is the Peabody Rebus Reading Kit. She is presently using Introducing Reading, Book 1. She has found this program quite good for deaf children for many reasons. Among these reasons are: 1) she can teach sign language at the same time she is teaching reading; she can show the picture and simultaneously teach the sign, 2) the units are short - she finds this very valuable, 3) it is programmed, 4) there is an immediate reward for the correct response, 5) the child is actively participating, 6) there are not too many words introduded at one time; in the first section, only ten words and four colors are introduced; 7) there is a review mask for the child who has trouble-the teacher finds this very valuable, 8) there are supplementary cards to help match and learn words. Also, these are especially good for children with visual limitations because the pictures in the book are too small; the cards are darker and bigger. Miss D. can also adapt this by using the same picture and word on the overhead projector, a machine she finds an invaluable aid. The child must tell her the sign for the picture on the machine, 9) there are even bigger pictures which are in color. These are supplementary and are based on the vocabulary to be used for language development. The size of these pictures is good for class use, and again, for those children who are visually limited, there are also sentence cards, which the teacher adapts and use for sign language. The levels get progressively higher and more complex.

The children must tell the teacher, in sign language, what the sentence card says.

Miss D. likes this program very much because it is so visually oriented, and this is one reason it is good for deaf children. Miss D. would like to see further adaptations of the symbols in the book using real signs. For example, - is in the book. In sign language, it is represented by the pinky finger acting as i coming out of the mouth. Miss D. would like to see this in picture form. In addition, the book has a STOP sign enabling the child to work independently for a certain period of time, with an indicated finishing point. There are also symbols for the teacher to clue in to new skills or new words or to check at a certain point. Miss D. finds this also helps make the program a success with her class.

As mentioned earlier, Miss D. also uses the overhead projector frequently. It is invaluable to her in helping to create experience charts for reading general language, sign language, lip reading, and auditory discrimination.

Miss C. has a group of children ranging in age from six through ten and one half. Some are at the readiness level. Miss C. uses the Matrix Language Set by Gotkin. This incorporates language and readiness activities naming objects and talking about actions in pictures. Part of the program also helps in memory training-the child must remember what the teacher said. Sequential activities are also included. Miss C. finds it quite good, especially for individualized instruction.

For those children who are at pre-readiness, and have had no experiences with books, Miss C. uses The Dubnoff Perceptual Motor Exercises, She finds that this series is so color-cued that it almost forces the child to be oriented inleft-right directionality. The program is used on an individual basis, and the children can work independently with it. Miss C. finds the program very effective.

Miss C. had considered using the Michigan Language Program, but because of the low functioning level of the children, she felt that they needed concepts more than skills and mechanics of reading. This might be useful if started at a later date with them.

Filmstrips are also used a great deal. Miss C. especially likes the Weston Woods series. Following the viewing is a discussion for sequence, memory and comprehension.

Taking a trip and cooking become direct experiences for reading. Experience charts are an important part of this class's work.

Miss C. used ABC - Read and Write, which is part of the Open Highways Series with two children. She felt that this was just an experience in writing letters. To reinforce she uses alphabet games and language lotto games. Miss C. prefers Writing our Language, a handwriting book.

The Peabody Language Development Kit was used earlier in the year, and was found to be extremely valuable by the teacher. It has good materials and a lot of visual aids, puppets, for example. It contains excellent picture cards from which a story is made. It also has excellent records, such as Sounds in the City, which Miss C. found very meaningful for the children.

Miss G's class has an average age of eleven. Two children, one nine, and one thirteen, are using The Bank Street reader. They originally started with sight word cards and phonic rummy. These children also use the workbook that goes with the reader. Miss G. finds that it is clear and there is not too much on a page; she finds this particularly good for Brain-Injured children. Two of the other children in the class, who are not deaf, are using the Rebus program. Both are doing well with it, and enjoy working with it very much. Three are working on readiness skills. Two of these are working on Dubnoff, Level 2, for perception. However, Miss G. finds there is very little carry over to actual reading.

All the children are using Writing Our Language; Miss G. finds it quite effective. She had initially used the Open Highways series, Read and Write, but the children did not enjoy the content. Their interest level was extremely low.

For visual motor perceptual teaching, Miss G. uses Teaching Resources, and Educational Service of the New York Times. This kit contains puzzles of fruit and animals. The children enjoy language lotto, too.

For phonics, Miss G. does not use a specific program; instead, she works with the group at the board. For reinforcement, the children play a Teaching Resources game called "Show You Know-Then Go" phonics game. This can be modified a great deal. The children also enjoy a Teaching Resource picture rhyming game. "Make-A-Word" spelling game, by Philograph Publications, is good for reinforcement.

Pegboard Designs, by Developmental Learning Materials, was found to be too complicated and confusing for these children.

Miss S. has a group with an average age of fifteen. She has three reading groups in her class; one consisting of six children, and two who are individualized.

The six use Open Highways Book 4, and use the workbook with it. Mrs. S. adapts the series in the following manner. She puts key questions on the board. First, the class reviews them orally, and then the students write the answers. They also answer questions related to concepts in the story. For supplemental work, Mrs. S. uses "Continental Press" materials. She specifically uses Reading and Thinking Skills, 31 & 32, which she finds excellent for skills of judgement, organization, and inference. The Barnell-Loft, Levels B and C are also used. The children work independently in this series. Different children in the group use different books. She finds this an excellent series, and because it lends itself so well to independent work, she is free to work with the children on an individual basis. In addition, the Scholastic Weekly Reader and Experience Charts are used.

One girl is reading Open Highways, 22. She uses rexographed material, and the workbook, with it. She also uses Barnell-Loft, Level B, and A, and many teacher-made materials. As review, she uses the Word Attack and Comprehension Book of the Michigan Language Program. One other girl is working from the Michigan Language Program; she has completed Reading Words 3, 4, and 5, and the Word Attack and Comprehension.

In addition, she uses teacher-made materials, Barnell-Loft, Level A, and a lot of word games, such as Scrabble for Juniors, Word Bingo, etc. This girl also uses workbook sheets from various workbooks. These sheets focus on her specific needs.

All but one child are in the spelling group. The class gets five words a day; the stress is on word families. The children write sentences with them. On Friday, they receive a twenty word test.

A great many word games are used in this class. As an example, given one large word, how many smaller words can you make from it?

Last year, Mrs. S. used Bank Street. She did not like it; she found the workbook very phonic oriented, and this was difficult for some of her children, especially those who have speech problems and cannot produce the difference between words, or those with auditory problems who cannot hear the differences.

Mrs. S. likes the Man in Action Series, which is geared towards oral language development. The children must make up a story about some pictures. This is good for sequencing and comprehension. She also likes using the Michigan Language Program because there is nothing oral required for a non-speaking child, and such a child can learn to read without having to read aloud.

Miss D.'s group consists of twelve through sixteen year old children, who are very low functioning.

At the beginning of the year, Miss D. started working with the Rebus program. Interestingly, she found that it was of little value for her class. The children could not comprehend it; it was too confusing for them, and there were too many factors involved for them to cope with. She then went back to the Bank Street Readers with two of the children. They started at the beginning, and are now at the end of the 3rd reader-Uptown, Downtown. Six of the children are on the pre-primer level of this series. They use both the reader and workbook. Even one of her students in this group, who is a very disoriented brain injured child, is having success with this program. Miss D. likes it because it is simple, and sequential. It also introduces a little at a time, is repetitious, has large print, and is very visually oriented.

Mrs. S. has a class of 12-17 year old students. Half of those have a primary handicap of deafness, two are primatily cerebral palsied with speech involvement, but their hearing is normal, and the other two are autistic.

One child is on a fourth-fifth grade level. He uses the Open highways series as a base. Beyond that, the teacher uses newspapers and books of interest to the child. At present, she is doing a lot of dictionary work with him. Her feeling was that for reading, she tries to maximize on his own interests.

With the other students, Mrs. S. uses the Rebus program. She finds this a valuable material for use with deaf or language impaired children.

She, like Miss D. who likes the Rebus program so much, feels that children who have to rely on sign language can read to the teacher in signs because of the pictures involved. This makes it easy to test comprehension. It is also good for those whose speech is undeveloped or impaired because they are not overwhelmed by the materials. Initially, they just have to recognize the picture. Later, they learn the written form. Also, the program is given in small doses, which Mrs. S. finds quite good. The students get the idea of a sentence through symbols before they even get to specific words.

Mrs. S. also does a lot of supplemental work, mostly seat work, involving naming colors, following directions, etc. She feels that these activities, while good for their own value, are a preparation for future activities in the Rebus program.

Mrs. Z's group are eight to twelve years old, and are deaf, hard-of-hearing, and have both expressive and receptive language impairments. They are not a very academically oriented class.

The two children who are academic are reading the pre-primer level of the Bank Street reader. The teacher adapts this program by making up her own worksheets, which consist of questions about the stories accompanied by patterned answers. The workbook, she feels, is no good, because the children cannot follow the directions. Mrs. Z. makes up her own sheets for directions.

For the less academic group, Mrs. Z. started with nouns and drew pictures of them. The word was written both on the top and on the bottom of the page. The first letter was dotted, and the children had to transfer the other letters down. They colored the picture, cut it and the word out, and matched the word to the picture. Mrs. Z. found this to be a good activity, as it utilized other skills, too, such as cutting. Then, Mrs. Z. began to use the Rebus program. The children liked it, and did well until they got to colors. Now, since they do not know colors, they cannot go any further in the program. Mrs. Z. is presently concentrating on colors so that the children can successfully return to the Rebus program. She also uses many experience charts, with picture clues to make the words more meaningful.

Miss G.'s class of ten through thirteen year olds has many hyperactive, brain injured children. The reading range is from first through fourth grade.

One child is reading Around the City, a Bank Street reader. He also uses the workbook. In addition, he also reads "Moonbeam and the Rocket Ride", which is part of Moonbeam Books, Benific Press. These are high interest books. The child finds the content interesting. Miss G. also makes up her own worksheets related to the stories. They deal mostly with comprehension. Two of the children are now finishing Around the City. The same type of procedure is followed. Four are reading "My City", and are all on different stories in this book. They work at their own pace. All have worksheets that are appropriate to their individual needs. Some of the children are capable of working independently, and request Miss G.'s help only if they need it. Others work directly with the teacher, as they cannot work alone yet.

Each day, an experience chart is written from which every child reads orally. These experience charts deal with current events, both in the class and in the world. Miss G. finds this very useful with her class, as she can consistently correct speech problems through the oral reading, and in this manner, other subject areas are incorporated. She also finds this lends to the reading experiences.

One child is on the fourth grade level. He is visually impaired and uses the large print version of High Roads, by Houghton Mifflin. Miss G. finds that this has been effective. The children also use Continental Press materials for phonics, social studies, and science. She finds these materials quite good in their content and structure, and they are excellent reinforcement for reading.

Mrs. G. has seven children, ranging in age from ten through twelve, and one child who is fifteen.

Two children are reading. They are using "Around the City". A Bank Street reader. They are using this because it is what was available at the time she was looking for reading materials. She takes vocabulary manual; instead, she creates her own materials. She takes vocabulary words from the reader, and uses them in phonics. The children do not use workbooks, but instead are making their own out of rexographed materials. She also uses a Bingo game for phonics. She finds that the children are making excellent progress.

Two girls are on reading readiness. Mrs. B. uses teacher-made materials, mostly. The children copy shapes a great deal. They do use the Dubnoff Sequential Perceptual Motor Exercises and Fitzhugh Plus Program for Shape Matching. Other rexographed materials are used for recognition of same and different, and generalization. Mrs. B. also feels that there is carry-over from certain math readiness skills, such as patterning and sequencing.

Mrs. B. also uses Read and Write, Concept Starter (Scott-Foresman) for picture identification and matching games. Mrs. B. tears these books apart, and mounts the pictures on index cards to be used for the above purpose. Mrs. B. also tore apart a writing book so the children could practice the letters they needed.

Miss W., has a class of eight children, ranging in age from eight through eleven. Five of the eight work in a group, and three are on individual program.

The five who work in a group are using the Michigan Language Program, which the teacher has found to be an excellent program for beginning readers, or for those who have not been able to achieve success with anything else. The children learn a sign vocabulary through stories that are extremely simple. The stories are in small pamphlets, so the child has a feeling of success in being able to complete each one in a relatively short period of time. Every few days they have finished another book. These words are then analyzed through a series of transparencies, called Didac. The Didac actually does the teaching of the letters, paying attention not only to their names, but their shape, height, direction, etc.

The children are also working in a reading book, which teaches visual discrimination, a listening book for auditory discrimination, and a writing book for development of writing skills. In addition, the teacher relies heavily on her own materials, based on the program, for additional reinforcement, either in class or at home. The teacher finds this program effective because it is a total language approach. The children are bombarded by these words in every manner, so that they not only know them as sight words, but understand what goes into making them up. Also, the children can work independently at their own rate. There are STOP signs at various points. The teacher checks the work before the child can go on. As there are different levels of reading and writing, a child who has little problem with these need not do them, or can begin at a level appropriate for him. The program has built in provision for individualization. In addition, because a great deal of the program is visually oriented, it is easy for a deaf child to achieve success. These children who had no idea of what to do with a book are now reading simple primer stories. Another reason the teacher likes this program is that it teaches to a purpose i.e. reading. Its perceptual activities are in terms of letters and words; its a no-nonsense program. The children enjoy working in it, feels a great sense of achievement, and are glad to be able to work independently.

One girl is reading at a second grade level. She uses the Open Highways series. She has the reader, workbook, and rexographed reinforcement sheets that are part of the set. In addition, she answers written questions to the stories and spelling words are extracted from the stories. She writes sentences with these words. fills in the missing letter, etc. She has also completed the Barnell-Loft Series, Level A. These are excellent books for focusing in on specific skills. The child can work independently on these once she has the idea of what to do. The teacher has found this series invaluable . This child also uses Phonics We Use, Book C. Some of the exercises are good for reinforcement, but some have such complicated directions that a child with a comprehension problem would have a very hard time with it.

One boy is reading "Uptown. Downtown," the first grade reader of the Bank Street series. He uses the workbook, too. He is enjoying the stories, and likes working independently in the workbook. He also responds to written questions about the story. Miss W. does not find much difference between the Bank Street and Scott-Foresman. Both children are successful with the programs, and the teacher feels they would be successful in any program. It is the manner in which they are presented that makes them effective.

One totally blind child who is quite bright, initially used the old Scott-Foresman series, and teacher made materials. He easily learned to read with this program. Presently, he is reading individual stories of interest to him. For skills, he uses the Barnell-Loft Series, Level A. These are in Braille. He also gets spelling words from his story books, and has various tasks to do with them.

Miss W. had tried to use the Durrell Speech to Phonics program last year with her class. She found that the program is excellent, but at the time her class was not ready for this.

She plans to resume with this program very shortly. In conjunction with this, she plans to use the Durrell Murphy Phonics Kit, which the boy who is reading Scott-Foresman uses. He can work independently on phonics skills; the work sheets are simple and clear, and the answers are on the back, so the child can self-check. When the group of five is ready, Miss W. feels they will do very well with this.

At present, for phonics, Miss W. uses a set of large picture cards that have the letters in both upper and lower case on the back. The letters are large and very clear, and the pictures, although only black and white, are nicely done. The children enjoy various games that are used for initial sounds. In addition, there is a daily experience chart which started out with about two sentences in January, and now is up to about five. The children have gained a great deal of reinforcement in word recognition and left-right direction through oral reading of these stories. They also copy it daily into their notebooks, which has been a tremendous aid in their writing and organizing abilities.

The tape recorder has provided wonderful enrichment experiences. The children can listen to a story and follow it in the book. If they cannot read the words, at least the book comes alive through the pictures. There is a beep at the end of each page to indicate when to turn the page. These tapes are from the Library of Congress. However, the teacher can take any book and do the same. The children can listen to a story when their work is completed. They enjoy this, and look forward to new stories. Again, it is something each child can do by himself, which is good for him, and it frees the teacher to concentrate on another child.

Finally, the children often watch Sesame Street. Miss W. feels it is excellent visual reinforcement. The children, she notes, become totally absorbed in it, and starts saying the letters and words that are being presented.

This is part of the reading instruction at the Center for Multiple-Handicapped Children. Some of the same programs are used in different rooms. Other teachers are using different methods. Yet, in each room, there is success. Obviously, it is not a particular program or method that leads to success, but rather the approach the teacher takes with whatever materials she is using. The teacher here have shown a great understanding of the needs of the children, and have taught with these needs in mind. They have also been consistent, and have proceeded only when the children were ready. The result of my survey leads me to believe very strongly that, whether for normal or handicapped children, reading achievement is less dependent upon the materials used than on the teacher who is using them.

CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

The lunchroom is a place for good food, learning and socialization.

El comedor es un sitio para obtener buena comida para hacer amistados y para aprender nuevas cosas.

ADAPTING A SOCIAL LEARNING CURRICULUM TO MEET THE NEEDS OF A MULTIPLE-HANDICAPPED GROUP OF CHILDREN

Michelle Chiarella

Educators in the field of special education, more specifically, education of the multiple-handicapped, are faced with the problem of the scarcity of materials and curriculum geared toward this special child. The teacher is either left entirely to her own creativity and innovativeness or made to adapt programs and/or materials to accommodate the multiple-handicapped youngster. How much more convenient and appropriate when fewer gaps must be bridged. Such is the case when using a program for any handicapping condition. One such program in existence is the Social Learning Curriculum for the Educable Mentally Retarded developed at Yeshiva University and supported by the U.S. Office of Education. The program is divided into 11 phases, each dealing with a separate aspect of social learning, ranging from Perceiving Individuality (Phase 1) to Maintaining Body Function (Phase 11). It provides pre-tests and post-tests for each phase, allowing the teacher to assess the children's grasp of the material and to re-teach if necessary. The phase I have worked with and will comment on is Phase 1, Perceiving Individuality. The major purpose, as stated in the booklet (p. 12) is to provide the child with a basic grasp of self-identity labels and to promote interaction between the child and other children, between the child and another child and between the child and important environmental adults. This was enough motivation for me, the teacher, to experiment and adapt, if necessary, the materials and activities suggested. The importance of learning facts about self and developing a good self-image should not be overlooked in dealing with any child and more dramatically so, the multiple-handicapped child.

In using the Social Learning Curriculum, I had to take suggestions for individualization a step further.

Individualization should be employed in regular education, but in special education it is an integral part of the program. One of the first activities was to create a personal data booklet, whereby each child could collect information about himself and use it as a constant reference. It was suggested that tracing or copying models be presented according to the abilities of each child. However, I was faced with how to adapt a writing activity for an eight year old visually and perceptually impaired youngster so that she too could create her own personal data booklet. Each child was to title his booklet, based on writing ability. J., unable to trace, was presented with her booklet bearing the title, "MY BOOK", prepared in white letters, in contrasting texture, on a black background and J. did a fine job of coloring in the title using both color and texture as guides. Throughout the program, this child required adaptation of all fine motor activities.

Added to the requirement for very special individualized adaptations in special education, is the need for constant reinforcement. I had to provide for reinforcement in using the Social Learning Curriculum, since among the multiplicity of handicaps of the youngsters I taught, was the trainable level of retardation. In this group memory for facts is quite limited, although the children seemed quite motivated to learn such personal data as their ages, birthdays, addresses and telephone numbers. The program progressed rather slowly because there was a need for the children to retain one fact before presenting another in order to avoid confusion and frustration. The bulletin board was an important reinforcement tool, used after the lesson, with each new fact visually represented and remaining for as long as it took to learn it. One such bulletin board display was a birthday cake which included each child's name, age and birthday. In addition to the visual reinforcement, auditory reinforcement was gained by using a highly motivating game as outlined below:

The game was called, "Who am I?" and the children fished for facts, using a hand made fishing pole with a magnet and cut out fish with metal clips attached. One fish might say, for example, "I am 8 years old". The child who gave the correct response became the next fisherman. As the program progressed and a few facts were retained, a fish would read, "I am 8 and my birthday is November 23". The children enjoyed the involvement and the game really served well as a reinforcement activity. The supplementary reinforcements seemed to enable the children to retain a few of the facts presented in the Social Learning Curriculum.

Another consideration, when applying an existing program to multiple-handicapped children, trainables included, is simplification. For example, the ability to differentiate among age, weight and height seemed too abstract and confusing to the children and therefore I deleted some segments of the curriculum. It was necessary to determine priorities in order to allow sufficient time for retention. I decided for instance, that it was more important for a child to recall his own age than to work on the concept of age comparison. The concepts of more, less and younger and older, although important, were beyond the primary purpose I had in mind for using the program, that is, to teach self-identity labels and, hopefully, enhance the self-image. Also, for most of the children, recalling complete addresses and telephone numbers proved to be beyond their ability, and therefore had to be eliminated. As much as possible, I employed direct involvement, eliminating much abstraction. The program provided a story about two brothers with the stated purpose to evoke a need to learn one's address. The theme of the story was how the younger brother got lost in the park. However, the language was so complex that the children could not focus on the important elements. It was necessary to first simplify the story, and next have the children role-play it to understand the implications. Only after several attempts and many specific and appropriate questions did a few children arrive at the importance of knowing addresses. Simplification was another key to our use of the Social Learning Curriculum.

THREE SPECIAL SETTINGS FOR SOME OF OUR CHILDREN WITH HEARING AND LANGUAGE DISORDERS

Laurie DuFine, Carla Zimmerman, Marina McGoldrick

I. The early childhood class for primarily deaf children consists of eight children from six to nine years of age.While the most common disability is a hearing impairment, the children have additional handicaps which are the result of a variety of physical impairments,brain-injury, emotional disturbance, mental retardation and/or visual deficits.

The classroom is equipped with a Zenith FM auditory training unit. Each child has a training aid which the child learns to care for to insure prpper amplification. The children are able to clean their own aids and earmolds as well as check the battery.

The major goals in the classroom are socialization, communication, and academic learnings. The children are encouraged to use both academic and play activities to improve peer relationships. Many times, one child will help another complete a task. At times one child will act as the "teacher" for the rest of the class. These experiences are enjoyable and, at the same time, they improve socialization and communication skills.

Activities of daily living are stressed to enable the child to be as self-sufficient as possible. Thus, difficulties in toileting, dressing and eating are worked on with each child.

The children are taught through a total communication approach. They are learning to fingerspell as well as to sign. The use of sign language and fingerspelling in conjunction with speech has improved the ability of many of the children to communicate. Auditory training and speech reading are augmented by the use of analogous hand movements and pictorial representations of the speech sounds. The children also are cued to produce speech by using the hand microphone of the auditory training unit. As the children become more proficient in communicating through the use of speech and sign language, their abilities in all academic areas improve.

We use the Rebus reading program which allows for the combination of sign language and reading mechanics. The program has been very successful since we are able to use sign language, speech reading and visual clues together. The program is "success oriented". It allows the child to respond by making the correct answer and provides immediate feedback. The pupil is enabled to work at the rate best suited to achievement level and personal comfort.

The children also are involved in reading activities using experience charts and flannel board materials. Through the use of these materials, once again they are able to enhance their language understanding and communicate with others.

For teaching mathematics, we have found Unifix and Stern materials augmented by teacher-made dittoes to be very useful. concept formation is stimulated through frequent use of manipulative materials. Hopefully, the children discover by themselves a great deal about meaning of numbers and mathematical relationships. Attention to the development of perceptual motor skills is important for these children.

We often use an overhead projector to enable the children to trace symbols and patterns on the chalkboard.

Tracing activities using a flashlight whose beam must be followed also improves perceptual skills. Completing puzzles of varying difficulty and joining one dot to another to form a pocture are typical activities in the program.

In all areas of the curriculum, communication is emphasized. The children are encouraged to learn new language while playing in the gym, at the sandbox or while coloring. Throughout the day, every opportunity to learn a new work is seized in order to enlarge the child's language ability.

The children are formally tested each year on their progress with the Wide Range Achievement Test and the Metropolitan Achievement Test. These tests are difficult to administer to multiple-handicapped deaf children without adaptations. Teacher observation plus input by various members of our interdisciplinary team play a large role in determining the progress a child has made.

II. The middle group of primarily deaf children range in age from eight to twelve. In addition to hearing losses, other concomitants are mental retardation, perceptual difficulties, emotional instability, and mild to severe visual impairments. As with the early childhood class, an important goal of this class is socialization and good peer group relationships. Many of the children have not had prior schooling so class routines and a sense of responsibility are also stressed.

Since one of the great handicaps for these children is their lack of communication abilities, all lessons are taught orally and manually at the same time. Training in auditory perception and development of sounds is done kinesthetically and visually in cooperation with the speech therapist.

Academic work requires great preparation and frequent adaptation for individual needs. Here are some of the activities that have been found useful for our group:

The academic day begins with peer interaction employing a "who is here?" game. Through the use of fingerspelling and signing, we review "who is here?"

Names are finger spelled and written on the board. The alphabet is reviewed with finger spelling and clothing is discussed by color and type.

After this activity, perceptual work is done on the Board with the overhead projector. This is easy to monitor, and helps with patterning and working skills.

Mathematical concepts are also reviewed and further clarified by the use of transparencies. Individual seat work is done, but it is difficult to work with our children in this fashion because they need much one-to-one help and will often not work independently. However, this problem is helped through the use of materials and maintaining individual folders for all work. Handwriting and marking skills are practices in independent skill books.

We have also found that the Rebus reading program is most beneficial. It lends itself very well to our signing program. Unfortunately, the Rebus program presents difficulty for the visually limited child and must be modified for them. There are deaf signed stories for the children but they are used as story books and not as primary readers. In general, except for the regular reading series, most academic materials can be modified for the multihandicapped deaf child. Teaching machines (we use Borg Warner System 80) are adapted by signing the words and having the child complete the activity.

III. The older deaf class of eight children ages thirteen to seventeen exhibits, in addition to moderate to profound hearing losses, some of the following concomitant handicaps: visual impairments, mental retardation, brain-injury, physical handicaps, and emotional disturbance (some with autistic behavior). They range in ages from 13 to 17 years. Most of these children were referred for placement in our Center because they had failed to learn in a special education setting that focused on one particular handicap. A few of the children had never been in school because of the difficulty in finding appropriate placement for them. Often, a child has three or more handicaps, none of which is severe enough to permit the child to be served by a facility that specializes in one area. Our class provides an accepting, learning environment for these and other children.

Before detailing the methods used in our class, mention must be made of some of the equipment found to be extremely useful with the children. Amplification is furnished by the FM loop system. Each child is supplied with an FM training aid for use during school hours. I cannot overemphasize the value of this system. It permits the hearing impaired child to learn so many of the characteristics of consonants that could not be gotten through the personal hearing aid. Also, I should like to stress the importance of a room equipped with many areas for display of visual materials. A bulletin board should not be a static thing, beautifully decorated and allowed to remain that way for weeks or months on end, when it can be so effectively used for daily schedules, calendar work, attendance taking, changing classroom jobs assignments, information on upcoming holidays, and as a referral source for the children's personal information. I literally "teach" off our vast bulletin boards. In addition to each child's desk, it is vital that there be extra furniture in the room so that the teacher can create various learning areas. Our classroom contains two large round tables, which are indispensable. By conforming to a schedule which the children are aware of through a large illustrated chart, it is found that certain areas of the room become associated with certain activities. This helps the pupil not only to learn the names of the subjects he studies, but to know what type of activity to expect and what materials are needed to begin: paper, pencil, etc.

Thus, if a child is having a particularly difficult day the option of a more acceptable alternate activity is offered with the understanding that the original task is to be completed when the child is better able to concentrate. By using all bookcase and a screen, we have created a small "office" which contains my desk and an extra pupil's desk. I try to give each child at least five minutes of my undivided attention in that office. Most often it is for individual language work, but it can also be used for concentration on any particular activity the child may be interested in sharing with the teacher.

A primary objective in working with these children is, of course, to teach them to communicate. Because of the diversity of handicaps, the same method will not suit each child. So we try to present language in every possible way - speech gestures, sign and the printed word. The child is encouraged to communicate in whatever way he can - pointing, gesturing, signing, fingerspelling, or speech. Of course, with physically handicapped children any gesture or sign used is merely an approximation of the proper movement, so it is especially important to get the child to supplement gestures with as much speech as possible, and, if necessary, with the use of a language board.

For reading,we also use the Rebus Reading Series. It is an excellent reading program because the child learns to read pictures and symbols before having to learn the printed word. This is more natural, since, if possible, spoken language should come before a child actually begins to "read". It gives even the slowest child the feeling of success he needs. Also, the transfer from reading symbols to reading words has been quite smooth.

For mathematics, no one set of materials or books suffices. Among the many materials we use are beads, Unifix, Arithmeblocks, pattern boards, Stern materials, and counting rods. It is good to have the children experiment with all these materials at some time, so that concepts are presented in different ways.

For social learnings we use the curriculum developed by Yeshiva University. Of course, revisions to suit our group's linguistic limitations are made, but, in general, the topics suggested by this curriculum to offer excellent guidelines for developing very essential social skills.

PROGRAMS FOR SPEECH AND LANGUAGE

Blanche Fingeroth, Bonnie Kirschenbaum, Phillip Schneider

Three full-time speech teachers are responsible for the speech and language program at the Center. This article will describe case selection, programming of cases, therapy approaches and other functions of the speech teachers. The summary includes suggestions for setting up a speech program in a center for multiple-handicapped children.

At the start of the school year the entire student population of 128 is screened by the three speech teachers in order to assess the current needs of the children. The results of this screening help to shape the speech program. Each speech teacher screens one third of the children and reports results at a meeting of the speech staff. The following areas of observation are included in the screening: oral peripheral mechanism, receptive language skills, expressive language skills, and motor speech skills. The classroom teacher's help is enlisted in reporting speech and language behavior that may otherwise go unnoticed in a short screening. The following data were collected during the Fall 1974 screening.

ORAL PERIPHERAL MECHANISM

	Moderate	Severe
Malocclusion	13	9
Drooling	7	10
Asymmetry	1	2
Lip Incompetency	11	5

RECEPTIVE LANGUAGE

No response to language	8
Difficulty responding to language	23

EXPRESSIVE LANGUAGE

No verbal or gestural expression	13
Uses gestures primarily	11
Jargon and/or echolalia	11
Morphology and syntax problems	27

MOTOR SPEECH
(dysarthria and/or dyspraxia)

	Moderate	Severe
Intelligibility impairment	23	14

Note: Some children are listed in the data under several categories. A total of 89 children were clearly in need of some form of speech and/or language therapy.

Case histories are also reviewed in selecting the population for therapy. The uniqueness of each child's complex deficits militates against working in groups. Children are scheduled for two to four 20 minute sessions per week of individualized therapy.

Therapeutic approaches range all the way from games that stimulate language to a variety of behavior modification techniques. All students are recorded on video and/or audio tape at the beginning of therapy. Periodic re-recording allows for objective judgements about the child's progress. Many behavioral changes would go unnoticed without this recording procedure. Language samples of verbal children are transcribed and saved as pretherapy baselines for posttherapy comparisons. Formal testing using the Illinois Test of Psycholinguistic Abilities, the Peabody Picture Vocabulary Test, The Northwestern Syntax Screening Test and the Assessment of Children's Language Comprehension are used only to pinpoint primary areas of deficit and not to assign labels or scores to children.

There is an obvious need for the establishment of therapy programs for the large number of children with drooling problems. For these children we are trying an approach that combines stroking techniques suggested by the occupational therapist with a behavior modification procedure. The behavioral goal of this program is to attain habitual lip closure, since closure precedes normal swallowing.

Many of the severely dysarthric children evidence difficulty in chewing and swallowing as well as in speaking. Therefore, the speech teachers and the occupational therapist established a feeding program. Each child's reflex patterns are evaluated to determine proper positioning for the head and body during eating. An examination of the oral peripheral mechanism is performed to assess lip posture, tongue mobility, and swallowing patterns. Special utensils are used to facilitate self feeding skills. Parents are encouraged to participate in the feeding program to ensure home follow-up.

A total communication approach is used with children who exhibit severe language deficits related to hearing loss. There is also a group of children who do not respond to oral communication, and cannot be validly tested for hearing loss. These children receive a total communication approach similar to that given the hearing impaired children. Total communication as used here refers to the pairing of manual language with verbal language.

Language and speech work with all of the children in the school stresses the use of tactile, kinesthetic, visual and auditory cues. We have found a good measure of success in the current emphasis on the use of visual stimuli.

The speech teachers are responsible for implementing a hearing evaluation program. The Speech and Hearing Department of Hunter College offers three hours a week for speech and pure tone audiometry as well as hearing aid evaluations. In addition to this standard testing, all of our children are included in a special research project involving impedance audiometry to uncover middle ear defects.

Beyond the diagnostic and therapeutic services for children presently enrolled at the Center, the speech teachers participate in interdisciplinary evaluations of multiple-handicapped children who are candidates for admission to the Center. The speech teachers report contains a summary of the child's speech and language development, general behavioral reactions to the testing situation, an evaluation of the child's current speech and language functioning, and recommendations. A language sample is tape recorded and the diadokokinetic rate of single consonant vowel syllables and multiple syllables is measured. A picture articulation test is administered and tape recorded for phonetic analysis.. Subtests of the Illinois Test of Psycholinguistic Abilities are used as needed. The mean length of utterance is reported and morphological and syntactical forms are evaluated from the language sample.

Efforts are made to work with teachers in setting up programs for speech and language training in the classrooms. We try to make use of audio-visual equipment and materials which are available in the classroom so that extra time demands on the classroom teacher are minimal. Language Masters, Systems 80 learning machines, and tape recorders, among others, are used for classroom follow-up. Teachers and paraprofessionals have also assisted the speech teacher by presenting reward tokens contingent on behavior specified by the speech teachers. The child can redeem the tokens at the speech room. This team effort helps the child generalize the desired behavior. Conferences with teachers also focus on how to communicate most effectively with particular children.

Working with the speech and language problems of multiple-handicapped children presents many problems. An approach that stresses frequent objective measurement of the child's performance provides direction for the communication rehabilitation of these children. In addition, there is a real need for documentation of work done with these special children.

CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

Each child receives a carefully planned program of individual remediation.

Cada niño recibe un programa de remediación individual que ha sido cuidadosamento planead

A CLASS TRIBUTE TO DR. MARTIN LUTHER KING, JR.

Miss Kathleen George, Teacher

It has become the custom to pay tribute to the memory of Dr. Martin Luther King, Jr., every year, on his birthday. His life and the causes with which he was identified are especially appealing to those who are aware of, and those who suffer from the conditions which he sought to eliminate. Thus, it is now a regular practice at the Center for Multiple-Handicapped Children to make this observance a source of inspiration for all concerned. This year the need was felt to bring to life one of the many memorable events with which Dr. King was associated so that in honoring him there would be developed in the children a new awareness of his activities in pursuit of justice for the oppressed.

In this case the Montgomery Bus Boycott was considered a most suitable choice. The idea of black people being forced to get up and move to the back of a bus had been the subject of a skit in a Harlem Public School some years ago. It had been thought about occasionally thereafter, but only now could it "come alive", because an ideal cast was available. There were four very good readers who could be visualized as the main characters: Mrs. Parks (Lillian L., borrowed) from another class; Steven F., as narrator; James D., as Dr. King, and finally Kewin B., as Rev. Abernathy. The rest of the class, five in number could be depended upon to supply the one-liners and a wealth of fervor for the protest element.

Many conditions determined the scope of the presentation:

1. It could not be long. A few of the performers and a substantial number of the listeners might become restless since they all have special problems.
2. The message had to be very clear and easily understood.
3. There must be highly visible appeal in order to sustain interest.
4. It had to be within the capabilities of the performers.
5. A serious modd must be maintained out of respect for the subject.

Every effort was made to satisfy these requirements. The presentation was not over ten minutes in length. The narrator, our most advanced reader, had the use of a microphone which provided an extra incentive to speak clearly and with a steady rhythm. Thus, continuity and a smooth flow of the action were assured. The message - a woman being taken from a bus, arrested, and thrown in jail - was made visibly more understandable by having the "policeman" wave a "club" over her as she "struggled" all the way to the "jail" where she was in full view of the audience until the end when, victory having been won, she was "escorted" in a mood of prayerful thanks and jubilation out of "jail" by "Dr. King" to join the others in the closing moments of the presentation.

The excitement created by this beginning scene was sufficient to get and hold the attention of the listeners thereafter as "Dr. King" held his consultation with "Rev. Abernathy", then made his spirited appeal to his "Church members and others" who finally joined in the very vocal "protest march". This capsule recreation of the event, while probably not entirely faithful to details as they occurred, still attempted to portray the emotional climate, the rising anger, the resolution to take decisive action, and the elation following victory. Some of Dr. King's famous expressions were used, and the presentation ended with the singing by the performers and the Center Chorus of "We Shall Overcome," a fitting conclusion.

Each member of the cast felt comfortable in the role assigned. There was background work with maps and preliminary work with charts from which the various roles were read and studied. Each became familiar with the name and location of the place where the action had occurred. Other facts about Dr. King's birth, his upbringing, and his education were reviewed as is done from year to year. Dramatizing the facts and reliving this part of history, even on this small scale, became for each child a worthwhile learning experience. It demonstrated the importance of discipline. Success depended on each individual's exercise of self-control, the ability to listen, to follow instructions, to be attentive to what other performers were saying, and to follow the script in order to make his own appearance and contribution at the proper time. There was the daily practice of working together in harmony. This class is made up of children representing the three dominant racial groups in this community, and everyone participated in this effort. Self-respect and respect for each other are principles followed and insisted on in this class at all times.

Although the nature of the event being dramatized made it necessary to express a great deal of action and emotion, nevertheless, care had to be taken to preserve serious attitudes among the performers who tended to revel in the excitement. In these children, with their special problems, controlled behavior required the exercise of exceptional will-power. It can be said, to their credit, that this opportunity to channel their energies into legitimate outlets was used to good advantage. Each child experienced the satisfaction of having done a good job, and expressed the hope that there would be a repeat performance. The results were said to be impressive and not unworthy of the occasion or of the person to whom honor was being done. The presentation left the audience in a mood of subdued respect. It was gratifying to note that thereafter a fairly lengthy recording of Dr. King's famous speech, "I Have A Dream" was heard quietly by children who, as a rule, are restless, impulsive, and highly vocal for the most part.

Finally, an indication of the impact which the presentation had on the performers is that they were first to discover and call attention to a segment in the January issue of the children's magazine, Ebony, Jr. which presented a longer, more detailed dramatization of some episodes from Dr. King's life . They showed a keen awareness of the facts, recognised the persons pictured in the accompanying illustrations, and most of all felt a strong sense of pride in their involvement with the subject, his life, and his story. It is felt that this effort has proved the suitability of this presentation for use with small groups and special classes because of its moderate length, simplicity, ease of casting, and adaptability to large or small groups.

THE MONTGOMERY BUS BOYCOTT

(The Jailing of Mrs. Rosa Parks)

CAST OF CHARACTERS

Narrator — Rev. Abernathy
Mrs. Parks — Bus Driver
Dr. King — Policeman
Dr. King's Church Members and Others

NARRATOR: Dr. Martin Luther King, Jr. did many great things. The Montgomery Bus Boycott was one of his most important accomplishments. It began on December 1, 1955. (At this point begins a pantomime of the action being described by the Narrator)......

Mrs. Rosa Parks, a black citizen of Montgomery, was on her way home from shopping. She was tired. Her feet hurt. She got on a bus, paid her fare, and sat down. Soon some white people came on the bus. There were no empty seats. The bus driver told Mrs. Parks to get up and give her seat to one of them. Mrs. Parks said -

MRS. PARKS: I will not get up.

NARRATOR: And she did not get up. She was a brave woman. The driver called the police. Mrs. Parks was arrested and put in jail. (Pantomime of Mrs. Parks being arrested, struggling, carried off to jail represented by bars of a cell behind which Mrs. Parks is made to sit).

Now, we recreate a scene as it may have happened.

(Dr. King and Rev. Abernathy pacing back and forth deep in conversation)

Dr. King: Rev. Abernathy, we must do something to help Mrs. Parks.

Rev. Abernathy: Yes, Dr. King. You are quite right. This case is important to all of us in Montgomery.

Dr. King: I agree. What do you suggest?

Rev. Abernathy: I suggest that we talk it over with the Church members and the people of Montgomery.

Dr. King: Right you are, Rev. Abernathy. We must all work together. I will call an emergency meeting. There is no time to lose.

NARRATOR: And now, we recreate a scene as it may have taken place at Dr. King's Church.

(Scene at Dr. King's Church. He addresses the emergency meeting).

Dr. King: My friends, a very brave lady has been arrested and thrown into jail. Did she kill somebody? No. Did she steal something? No. What was her crime? She wanted to be respected. She got tired of insults. We are all tired of insults. Now is the time for action. What shall we do?

FIRST MEMBER: We should start a riot.

Dr. King: No violence, please. Remember, we are God's children.

SECOND MEMBER: Let's burn some of those buses.

Dr. King: Never. We don't hate anybody, not even the Bus Company.

Rev. Abernathy: Let's stop riding the Montgomery buses.

Dr. King: An excellent suggestion. We will ask all our people to help us in this struggle. We will take a long walk for freedom---until every black man, woman, and child can ride the Montgomery bus in peace. Are you with me?

THIRD MEMBER: Yes. We are with you.

ALL: YES. We ARE WITH YOU.

Dr. King: What shall we tell the Bus Company?

(Each person picks up a picket sign bearing the slogan which he reads as he gets up and begins to march in a prescribed circle. Each in turn follows the other in the march around the circle after he has read the slogan on his sign).

Rev. Abernathy: DOWN WITH THE JIM CROW BUS. (Picks up sign. Begins to march).

A MEMBER: WE WILL PAY OUR FARE TO SIT WHERE WE PLEASE. (Begins to march)

A MEMBER: WE ARE TIRED OF INSULTS. FREE MRS. PARKS. (Begins to march)

A SYMPATHIZER: FREE MRS. PARKS. (Begins to march)

A SYMPATHIZER: FREE MRS. PARKS. (Begins to march)

Dr. King: WE DEMAND EQUAL TREATMENT. FREE MRS. PARKS.

ALL THE MARCHERS: FREE MRS. PARKS. (They continue to march chanting this slogan, as many times as seem adequate. Then they stop, stand facing the audience each holding up his sign to be viewed).

NARRATOR: The Boycott lasted a long time. The Bus Company lost thousands of dollars, and was forced to change its policies. Now everybody in Montgomery can get on a bus, pay the fare, and sit anywhere. Dr. King and his followers had won their fight. (Dr. King goes to Mrs. Parks, takes her hand. They rejoin group).

ALL (JOINED BY CHORUS): Song - "We Shall Overcome" (They march slowly, in single file to their seats).

THE END

The following issues of Ebony Magazine were very helpful as sources of information:

SPECIAL ISSUE - September, 1963, page 37
ISSUE - September, 1968, pp. 154-162
ISSUE - April, 1970, pp. 172-182

MUSIC MAKES A DIFFERENCE!

JEAN MEURER

One could rhapsodize over the role of music at the Center for Multiple Handicapped Children, since it has brought so much joy to the pupils, staff, parents and guests. To hear our chorus burst forth in song is to forget the fact that most of its thirty children have severe communication disorders. To see the children with motor handicaps involving arms and hands play rhythm and percussion instruments is to make one aware of the transcendency of the inner spirit over the physical self. To feel the pulsating beat of Latin American music rise to a crescendo as the kids and staff are dancing (in the air it would seem), is to realize that, once again, physical restrictions and mental blocks are but mild obstacles to the willing spirit.

Our goals for the music program focus on the therapeutic effects which can be achieved through a fusion of the individual child's interest, ability and opportunity to participate. How we gain our objective is seen in the following case involving Don, a child who is diagnosed as deaf and severely disturbed.

Don, a nine year old boy, has a congenital hearing loss. His parents and siblings have normal hearing. He attempts to avoid conflict and frustration, is extremely shy and retiring, has a low aspiration level, and demeans his own accomplishments. He tends to seek relationships within the less threatening world of the deaf and prefers to sign rather than attempt speech. In short, Don is a severely withdrawn, deaf child with a low self-image.

Don's class attends music for thirty minute periods twice a week, so it is within this time setting that the training program is designed. The following goals have been set for Don:

1. To develop any untapped music skills
2. To increase Don's ability to enjoy and use music
3. To effect a change in Don's self-image, personal and social behavior through music
4. To expose Don to greater options for interaction beyond the more limited society of the deaf world.

In order to achieve these goals, the music teacher or therapist should know, among many other things. the child's auditory acuity, volume, pitch and tone discrimination ranges, and general intelligence level. With his hearing aids, Don does hear low but not high sounds, and he can understand language when it is spoken loudly and at a slow pace. He tests in the low average range of intelligence, though one may well question the validity of test scores in view of his hearing loss and reticent behavior.

The training program will be divided into the two basic elements of music instruction, pitch (i.e. melody) and rhythm. The teacher will begin with rhythm, since this child appears to have good motor and mechanical ability and because rhythm appears to be the easiest way to involve the hearing impaired child in music. It is important to have Don achieve and enjoy immediate success. The following list of activities utilizes rhythm, motor skills and, at times, pitch in attaining goals for children like Don. Such children may be asked to:

1. lean against the piano feeling 2/4, 4/4 beats with the whole body. This exercise is repeated before each lesson to establish basic rhythm.

2. sit with legs wrapped around drum. The teacher beats 2/4 rhythm and the child repeats the pattern on the drum.

3. sit on a wooden bench. The child beats on the bench with a rhythm stick. The teacher reinforces by tapping on the bench with the rhythm stick while simultaneously patting the child. Further reinforcement is achieved through strong tape recording in 2/4 time.

4. allow themselves to be swung by teacher and paraprofessional over a mat to a slow 2/4 beat .

5. sit on bench with teacher and paraprofessional with arms around each others shoulders swaying to a 2/4 beat.

6. repeat exercise "5" sitting on mats in a circle, and gradually add other movements (forward, back, circular), Children eventually repeat patterns with partners, holding wrists together and feet together; eventually imitating more involved body and arm movements as demonstrated by the teacher.

7. respond to visual clues given to the rhythm by turning jump rope to the piano or drum beat.

8. respond to kinesthetic clues given to the rhythm through use of the trampoline with the child bouncing to the beat of the drum. Instead of the trampoline an exercise ball may be used where the teacher or assistant hold the child on the ball and roll back and forth to the beat of the music.

9. sit in a circle on the floor. A large ball is passed from child to child as teacher and assistant clap, beat, or drum with stick on the floor. Children eventually bounce ball to partners.

10. jump from hula hoop to hula hoop which have been laid on the floor in patterns. The teacher plays the rhythm and the paraprofessional squeezes the child's hand on beat and jumps together with the child.

11. sit in pairs and "partner clap" to rhythms.

12. lean whole body against the piano. Pitch requiring different action is being introduced. The teacher plays massive chords moving from bass to treble using the same chord in its total range. Assistant holds up large colored cube for bass, small different colored cube for treble (assistant "signs" and says, "high" or"low"). Children with hand on piano try to repeat, and are given many visual clues through facial expression. Much praise given for effort.

13. use a set of six blocks of varying size and color in learning to match pitch to block size and color by lining up the blocks as a substitute for musical notes.

14. use a set of wooden stairs to learn the musical scale through ascending and descending motion.

While there are several methods of assessing the progress of the child through this training program, a teacher should be aware of the child's mastery at each level before proceeding to the introduction of a new skill. Ideally, upon completion of the program, the following criteria should be used to evaluate the effectiveness of the program:

1. The child should be able to do simple rhythm band exercises with sticks, drums and symbals. Almost every child with teacher assistance can evolve some method of handling instruments.

2. Some degree of mastery of formal drum rudiments may possibly be expected.

3. In relation to exercise "6" (introduction to dance movement), children should be able to play musical chairs, marching formation, and simple square dance (even in wheel chairs).

4. The child should be able to bounce a ball alone and with a partner.

5. A simple game of Hop Scotch should be mastered .

6. Some children could now be integrated into the chorus being given simple alto and alto-tenor voice parts.

7. The much desired emergence from withdrawal symptoms ought to be evident in the child's freer movement and greater receptivity to socialization.

While the program outlined has specific objectives for Don, one can see that most aspects are quite adaptable for many other children with or without hearing losses. Music for the handicapped is far more than enrichment. With creative and dedicated leadership, it has tremendous impact on the total progress of every involved child.

PUPPETRY

Blanka Kahan

There is a room in one corner of the Center which never fails to produce a series of gasps,"oohs" and "aahs" from visitors who are touring the Center. That is because they are unprepared for the sight of a stage heavily draped in blue velvet and adorned with large numbers of hanging puppets of all sizes, types, and degrees of complexity. A tall, movable mirror, a sewing machine and some benches round out the equipment in this "smaller-than-classroom-size" room. When the puppets come to life, then one is really struck by the incredible concentration, engagement, and joy of the participating children, for they are now masters of someone else's destiny; they are "pulling the strings", they can create their own world; they can release their emotions.

How can one measure the total impact of this medium on the progress achieved by so many of our students? The areas of influence are so numerous that the possible accrual of benefits is almost infinite in its scope. Let us briefly examine a few of the more obvious advantages that are obtainable for a multiple-handicapped population through puppetry.

Psychology: Puppetry is well known as a projective technique wherein the child releases innermost feelings. Personnel trained to observe and analyze the child's behavior and comments can gain great insights into areas of difficulty. Therapeutic gains are likely through the cathartic effect of releasing pent-up anger and hostility or in the euphoric state occasioned by the sheer enjoyment and satisfaction of role playing.

Neurological Organization: Simply listing a few of the areas of deficit so often attributed to developmental lags of brain-injured children offers obvious clues to the knowledgeable educator as to the remediation potential of puppetry: body image, eye-hand coordination, spatial orientation, laterality, directionality, fine and gross motor coordination, sequential arrangement, general visual and/or auditory perception, general and specific sensorial losses.

Speech and Language: The purely visual aspects of puppetry permit wide latitude in its use for children with hearing losses. the hearing impaired child with a potential for oral speech is encouraged to expand its use. The same holds true for children with dysarthric speech, aphasia or any other speech or language impairment. The development of inner language for the autistic child is encouraged and other seriously disturbed children are helped to develop receptive and expressive language. All children are afforded this enjoyable opportunity for language expansion.

Academic Learnings: How many fingers should the puppet have on one hand? How many minutes will we be on the stage? Who wants the big puppet? Make the puppet two feet long from the top of the head to the bottom of the feet. We can only use one fourth of the stage. Mathematics are obviously involved and consciously so.

Cinderella, read your lines loudly and clearly, and don't forget to memorize them by Monday. Will the fairy godmother help the prince read his lines? Will the stepmother ask her teacher to help in rehearsing the lines? The children are preparing to do Cinderella at an assembly program. Whenever possible, children who can read are encouraged to do so or to help others. Sometimes, the good reader may act as a narrator.

Social studies may be approached through puppets who represent community helpers, through dramatization of historical events, through ethnic and national celebration of outstanding persons or holidays, and in myriad other ways. Any area of the academic curriculum may be included, for puppetry mirrors all aspects of life.

Socialization: Puppetry offers opportunities for either individual or group experiences. At the Center our concentration has been on fostering group interaction so that the withdrawn or shy child may emerge because a non-threatening or less self-conscious atmosphere exists. The child with a flair for dramatics has an opportunity to satisfy the submerged talent. The sharing of the common experiences, the close physical proximity as the children play on the tiny crowded stage, the appreciation shown for each child's contribution by the staff or the other children are all stimulants to the social growth of the students.

Physical Habilitation: While the restoration or strengthening of physical functions is not a direct role of puppetry, one can easily see the direct relationship between the required fine and gross motor movements of therapy and puppetry. Less obvious, but highly operative are the motivational aspects of puppetry which induce the children to spend relatively long periods of time in functional use of body parts. Nor does it require any prodding for a child with serious loss of arm and leg activity to scramble up a number of steps onto the puppet stage.

The puppeteer is bolstered and sustained by the sight of children happily engaged in an activity that is educational, therapeutic, and recreational. Forgotten are the deficits, the disabilities, the handicaps. Here, each child participates in a way that makes him the equal of any other child, for all children make their own world.

IT WORKS!

ANNE POTTER - STEVEN BERMAN
School Psychologists

It seemed too much to ask of one small special school, to take children who couldn't walk, children who couldn't talk, some who couldn't see, couldn't hear, couldn't learn, couldn't sit still, couldn't relate and just couldn't make it in any other school setting.

Yet that was just what the Center for Multiple Handicapped Children was set up to do - to take those children who presented such a difficult combination of problems that even New York City, with all of its special classes, could not find a suitable place for them. Many had never been in school at all. Those who had, had not made a go of it.

There were to be 16 classes serving 128 children. How could one possibly group children ages 4 to 18, whose intelligence ranged all the way from low trainable to superior? Children with almost every type of sensory and motor handicap? Blind children with deaf children? Paralyzed children with hyperactive brain-injured children? Those who were so withdrawn that they were all but unaware of their environment with others, so aggressive that they literally hit out at almost everyone in sight? As school psychologists we looked upon the project with considerable misgivings. It seemed as though it just couldn't work.

But it has!

Last year we "graduated" fully one-fourth of our student population. They went on to all sorts of special educational settings - school for the deaf, classes for brain-injured children, classes for retarded children, health classes, etc. Several of our older children went into vocational training programs. Yet many of these same children had previously been unable to qualify for these classes or had been unable to adjust in them.

Let's take Jimmie for example. Jimmie is deaf and came to us with little speech. He had been unable to make it in the school for the deaf because of his angry,aggressive, difficult behavior. He is back there now and doing well.

Or Timothy, a good-looking pre-teenager with a severe learning disability intertwined with a personality problem which made him the butt of his classmates "humor"; so much so that he had became a chronic truant. Tim, together with a classmate from the Center for Multiple Handicapped Children, is now in a "mini-school" within a large vocational high-school and reportedly making a good adjustment there.

Or Fernando, an appealing mite of a five-year old deaf, cerebral palsied boy with a charming grin. He could barely crawl when he entered the Center for Multiple Handicapped Children and had no speech. By last Spring he was scuttling down the hall on crutches and speaking in short phrases. He is now in a school for the deaf and one of their favorites.

Of our 20 graduates last year and 10 of the year before, all but two are reportedly "making it". And it looks as though another good-sized group will be ready for a less protected setting by this coming Spring.

But the "statistic" of the number of children "graduated" reflects only one facet of the picture. The other, the larger aspect, is much harder to pin down. It can't be expressed in statistics. It has to do with those intangibles - self-concept, sense of personal worth and the ability to obtain joy and satisfaction our of life - qualities difficult to define but which are the essence of what goes into making life worthwhile for every human-being, handicapped or otherwise.

And it is in these intangible areas that we feel our Center has really made a difference in the lives of our children - not just for the "graduates" or the potential "graduates", but for almost every unfolding little human-being that we have taken in.

There are many children in our Center whom we can't hope to "graduate". They will stay with us until they reach the maximum age of seventeen and then, in all probability, they will be transferred into some form of sheltered environment. Many, with more hopeful potential won't develop as rapidly as we might wish and may stay with us for a long time. But virtually all of our children will have shown subtle, yet profound changes in their sense about themselves. These youngsters, most of them coming to us with very profoundly damaged self-concepts, will have gained a feeling of importance, of being significant, cared-for and worthwhile individuals. In short, they will have come to feel that they have a place in the world and that the world has a place for them.

This is difficult to document, but it is there. One feels it immediately in watching the childrens' face light up with pride when they master a task in the classroom, or in the happy, noisy scramble down the halls for lunch, or for that matter in the unending comings and goings through the halls at all times of the day. And especially does one feel it in the assemblies, in the enormous joy and pride the children display when they are putting on a "play" or singing a song for their schoolmates.

To put it a bit more professionally, the greatest gains shown by our children have been in the areas of personality development, ego-growth and self-concept.

Let us look at Jeanny for example; Jeanny is a moderately retarded little girl with a terribly deformed face. When she first came to school she spent most of her time hiding under her desk and for a long time could not be induced to even look at a stranger. If someone entered the room, she would either dive under her desk, or, if caught unawares, would bury her face in her arms.

You should see her now: she rushes up to the school-guard in the morning and plants a big kiss on his cheek. Or sits with her classmates in assembly, giggling and chattering or unselfconsciously absorbed in the "show"- just like the others.

A much more difficult child, partly because she was much older, was 12 year old Nancy. Nancy, a thalidomide baby, was born without hands and then promptly abandoned by her mother. Life had piled misfortune upon misfortune for this youngster so that she become a terror in whatever school had attempted to contain her. She was a terror for us, too, sometimes literally so, since hooks (in place of hands) can become formidable weapons. It was a slow and difficult struggle for Nancy, but you should see her walk down the hall "hand-in-hand" with Tommy now, or stand up and sing a solo in the school chorus, or "inform" the psychologist that, since she is best in reading, in her group, she should be moved in with the older kids.

Or take Ken, a handsome, bright but very bizarre, withdrawn boy. He came to the Center for Multiple-Handicapped at age seven. He could speak, but what he said made sense only in terms of his own inner preoccupations. It was all but impossible to maintain him in the classroom; the whole class fell apart whenever Ken went into one of his (frequent) wild episodes. We moved him in with older, more physically disabled and mostly, retarded youngsters. Ken calmed down. He began to relate - at first just to his teacher - no one else appeared to exist for him. With her he learned to read. Then apparently other children begun to come into focus for him; first one, then another of his older, more stable, but less intelligent classmates. Now, Ken seems one of the best "put-together" children in his class.

In short, we have brought a large number of our children to a point where they are ready for other school settings; others are progressing in that direction. Many will not be able to move out at all and will stay with us until they reach our maximum age. But most have made impressive gains; many in terms of physical progress, some in terms of intellectual and educational advancement, and virtually all in terms of social relationships. ability to get along in a group, and in inner self-confidence.

We are not here addressing ourselves to the educational gains, nor to the physical development, the progress in speech, ambulation, etc.; gains attributable to the hard work of an excellent teaching staff and abundant supportive services. As psychologists we want to look at some of the ingredients that have gone into the really impressive gains on the personality side, in terms of ego-development and social-emotional adjustment.

In trying to understand and analyze the factors which have helped our children "grow" emotionally, we again come up against intangibles; intangibles such as "atmosphere", "group process", etc. But intangible or not - they seem to be crucial.

First, ours is a small school, only 128 children, 16 classes and an indeterminant amount of staff (we will get to that later). The school is all on one floor and uncomfortably cramped for space. The smallness has presented many problems, but it has one enormous advantage for the children. Nearly every adult and many of the older children know every child in the school. This goes for the bus-drivers, the school guard, the office staff and kitchen staff as well as the pedagogical and clinical sections. It means that within a short time after arriving, the child has the comfrot and safety of having everyone greets him by name.

It means that the child can relax since he knows that the staff doesn't expect an answer if he can't speak, isn't shocked by a deformity, and won't "hit the ceiling" if he utters a four letter word. It is an important part of creating an accepting, warm atmosphere, for the child.

Obviously, the atmosphere stems from far more than this. Perhaps a part of it is that every adult knows that these children are here because they could not make it anywhere else. We cannot be startled or too dismayed by either the physical disabilities or the "way-out" behavior. Nobody is placing too high expectations on these children and we know that we do not have the alternative of shipping them off to another school or suspending them. This is the end of the line and we must somehow accommodate them. One of our worst "behavior problems", Nancy, the girl born without hands, openly challenged us by saying that no school had been able to keep her and "we would see; we would throw her out too". And there were times, I'm sure, when many of the staff wished that there were some alternatives - but we have not suspended any children, and that knowledge must somehow translate itself into a basic security for the children. In the end we convinced Nancy - and she convinced herself - after some hair-raising "testing behavior" on her part.

But beyond this atmosphere of acceptance there is something even harder to define. The school has a cheerful, loving quality. Now, how does one analyze this or determine where it comes from? By and large our staff seems to love these kids and to be genuinely happy to see them on Monday mornings. The kids reciprocate and generally seem quite joyful to be back. There is a lot of kissing and hugging after holidays, and almost everyone on staff seems to be aware of and show real pleasure in any piece of good-fortune or progress for any child. It seems that our school is one succession of birthday parties and other celebrations, and while this may be hard on academic progress (and on the waist-line) it does make for a lot of interclass visiting, noise and excitement.

Conversely, if a child is out ill or (as is tragically frequent with our children) in the hospital for yet another operation, his classmates are aware of it and, to the best of their abilities, send cards, telephone and make a big fuss about him when he returns.

There is something else that goes into this warm "atmosphere". Something that, as psychologists, who having worked in many schools, we found particularly startling. The children are respectful of one another!

The assemblies are a phenomenon in this respect. These brain-injured, retarded, deaf and everything-else children, will sit for long periods, giving rapt attention to their schoolmates attempts to sing, dance, act in little plays. Despite untold errors, constant need of prompting, losing track of what they were about, it is the greatest rarity to hear one child make fun of another. In class, if a child goes up to the board and gets "stuck", no one giggles.

Far from taking out their own frustrations on their classmates, each child seems to draw sustenance (whether consciously felt or not) from the knowledge that everyone here has something the matter with him. One little mute boy, writing a letter to his absent teacher, pointed to the letterhead on our stationary, (Center for Multiple-Handicapped) indicated that everyone here is handicapped, pointed to psychologist's ear since she, too, wears a hearing aid. As a corollary, the children with better ego-development tend to be helpful to the other children and not just those in their own class. The children who can walk, however clumsily, are eager to push the children in wheelchairs or fetch things for them. The ones who hear better shout misunderstood instruction in the ear of a deafer classmate. They interpret for each other, help each other eat, or pick-up scattered toys and other objects. If only siblings in a normal family were so compassionate.

And this quality of the children helping, complementing and reinforcing each other goes on in a far more fundamental sense than in one child's pushing another in a wheelchair down the hall to lunch. What at first seemed like the most formidable obstacle to educational planning, the problem of accommodating children with such a wide range of age, intelligence and diversity of handicap, proved to be one of our greatest assets. In more than a biblical sense, in our Center, "the halt shall lead the blind".

The common practice, in "special education" facilities has been for children to be grouped roughly according to disability and age. Deaf children with deaf children; retarded children with other retardates; schizophrenic children with other schizophrenics. This certainly makes for greater ease in terms of teaching techniques and may appear, on the surface, to make good sense. But if everyone is in a wheelchair, who is going to push? And if every child in the class is "way-out" in his own private, self-absorbed world, what child will go in there to grab his hand and make him join the circle? A class of aphasic children, where is he to hear other children who speak normally?

Let's go back for a moment to Ken. As we mentioned, he started out in a class of youngsters roughly his own age and intellectual level. Many were brain-injured. When he had one of his near-psychotic rage episodes, the class dissolved in chaos. But when he was placed with other, more placid, physically handicapped youngsters, none of them seemed the least bit impressed with his wild carrying-ons. On the contrary, they seemed to regard him as a useful little guy who became something of the class mascot.

He could run errands for his more handicapped classmates, push them to the bathroom, and soon, read to them. His behavior shortly calmed down and he slowly began to really notice, first one, then the other of his classmates; much later, other children around the school.

Similarly, it is tremendously important, even for totally deaf children to be around and see other children who talk; for brain-injured hyperactive children to experience others who have better control, and so on down the line.

There is another factor which the mention of the brain-injured child brings to mind. As psychologists we had accepted as axiomatic that the brain-injured child needs "structure", a reduction of stimuli, holding change to a minimum, and so forth. We were frankly worried about having our"brain-injured" children exposed to the excitement, noise and change that seemed so much part of our school environment. Particularly were we concerned about the impact of so many, many adults who seemed to come and go in our Center. In addition to the teacher and paraprofessional regularly assigned to each class, the child is exposed to literally dozens of other adults in the course of the day. There are the substantial number of supportive personnel; the speech therapists, occupational therapists, physical therapists, doctor, nurse, psychologists, social worker, etc. Then there is a whole group of student-teachers, student-psychologists, art-therapists, music-therapists, etc., and countless visitors. Often children switch from room to room, puppet-shows, all kinds of entertainments. Surprisingly, this impressive array of extra "help" and interested visitors, this wealth of movement and stimulation and "enrichment", proves far more disorganizing to the adults than to the children-even the "brain-injured" children for whom we had such misgivings.

As psychologists we ran into an amusing corollary to this. We had been well-schooled in the belief that quiet and privacy are essential while testing. But since we had students of our own and many interested observers, we began, with caution, introducing one other adult into the room while testing. Often, both psychologists tested together in order to pool observations and, frankly, so that we could better manage some of the wildly hyperactive or disturbed children. To our surprise, the children seemed totally unperturbed by the presence of visitors or actually enjoyed the audience. We found that we could have as many as two, three, or four in the room without their batting an eye.

We began to realize that there is a positive side to all the extra adults passing in and out of these children's lives, to the many assemblies, to all the visitors. Part of it is that the youngsters gradually grow inured to "exposure" - something that often has been painful to our atypical children. But of far more importance, they are unconsciously absorbing something of the idea that beyond their "own" teacher, their "own" classmates, the larger "outside world" can also be an accepting and loving place.

True - and sadly, most of our children are going to find, as they move out into that "outside world", that there is a lot of difference, rejection and downright cruelty, too. But we hope, and we believe, that the inner sense of being loved, of being worthwhile, the inner sense of self-respect which they may have gained during their stay at the Center, will serve as a source of strength and courage when they do move into that "outside world".

THE ROLE OF THE SOCIAL WORKERS AT THE CMHC

EDYTH BRUCE, SYLVIA SHAPP

The original proposal for the establishment of a Center for Multiple-Handicapped Children included the services of two social workers. These workers were assigned from the staff of the Bureau of Child Guidance on a full time basis. They are part of the clinical team serving the educational and habilitative needs of the children.

The activities of the social workers encompass many areas. One of the most important relates to intake procedures which may be divided into two aspects, pre-screening and full screening. Let us investigate their pertinence to our setting.

Pre-screening entails a review of material from referring sources which should include a psycho-social history, current medical information, psychological test results, and a summary of the child's history in other educational settings. From this information, the children who are presumptively eligible for placement at CMHC are selected for an in-depth screening. Consultation with other members of the clinical team is available to determine the appropriateness of the referral. This method of pre-screening evolved from our experience during the first year of operation when we were attempting to do a study on all referrals and discovered that at least 50% of the children were not eligible for the Center. We recognized that many referral sources were not fully acquainted with our criteria for admission and through the pre-screening process we developed a dissemination of information program about the purpose of our Center. We did make recommendations for a more appropriate educational setting for children who could not be admitted to the CMHC.

Our full screening provides necessary information concerning the family and child. The parents learn about the services of the school and an initial assessment is made of their ability to accept ongoing contact to help the child benefit from the educational process. Besides the clinical team there are other disciplines involved in the intake screening including the physician, nurse, classroom teacher, speech therapist, occupational therapist and physical therapist.

After the intake screening in which team members have completed their individual examinations, a diagnostic evaluation conference is held. At this time the social worker contributes her collected data which is then integrated with the findings of the other members of the team. A decision is made as to the child's eligibility for admission to our Center. If the child is accepted, we begin to formulate an individual prescription encompassing all the modalities of treatment for the youngster.

Professionals from referral and other agencies are invited to attend these conferences. The social worker communicates the decision of the conference to the parents and the referral source. If we are not able to admit the child, we assume the responsibility for recommending an educational resource which we consider appropriate.

When the Center is ready to receive the child, the social worker facilitates the process of admission. Once the child is attending the Center, we move into the role of clinical services which include individual work with child and family, crisis intervention, consultation with the extended team family, clinical liaison with outside agencies, and periodic re-evaluation of the child. The social worker is aware of the special needs of the families and seeks out other services in the community that will help in the growth and development of the youngster and which will contribute to a better adjusted family. The time comes when the child is ready to "graduate"; which, in reality, means he is ready to move into a less protective setting. Usually, the placement is a special education class which is part of a cluster in a regular school. To facilitate the transfer, the social worker is part of the team that helps to select an appropriate facility. After transfer, periodic contact is maintained to evaluate the progress of the child.

One might ask how the role of the social worker at the Center differs from the role in other school settings. Our presence five days a week allows for the testing out of various modalities of treatment. Since we are available to school personnel on a full-time basis, there is a constant interaction which enables us to deal with both emergent problems and the fulfillment of long range goals. We get to know all our children intimately and are enabled to establish warm relationships. We often hear from referral agencies that we should accept their child "even if he doesn't completely fit your criteria because there is so much love at your place."

In addition to our regular contacts with parents, one of the social workers acts as liaison with the Parents Association. We have become aware of the commitment of the parents to the Center as a setting that has helped their children. Such an attitude has made our job easier and tremendously rewarding.

THE GUIDANCE COUNSELOR AT THE CMHC

Rena Yasgour

The Committee on Child Health of the American Public Health Association Defines the Handicapped Child as Follows:

> A child is considered to be handicapped if he cannot learn, work, or do things other children of his age can do; if he is hindered in achieving his full physical, mental, and social potentialities. The initial disability may be very mild and hardly noticeable, but potentially handicapping, or it may seriously involve several areas of function, with the probability of lifelong impairment.

The function of any educational institution is to meet the needs of the children in educational, personal, emotional and vocational areas. Children in special education have the same needs as other children. These children have greater individual differences physically, emotionally, and educationally. They have multiple needs.

The Center for Multiple-Handicapped Children is unique. Our children have many handicaps. These are the forgotten children. Until the creation of the Center there was no public school facility that met their needs.

Our population comes from various sources. Referrals are received from social agencies, hospitals, rehabilitation centers, public and private schools, and directly from parents.

The counselor takes an active role in the screening and intake process. The process involves an interview with the parent or guardian and the child is evaluated by the teacher, speech teacher, occupational and physical therapists, and a physical examination by a pediatrician. With the information gathered at the intake interview and the referral material, which should include a social history, a recent psychological, medical report and if possible educational evaluations, a case conference is held with all participating disciplines, which includes the guidance counselor.

It is after the child has been determined to be an acceptable candidate and prior to his admission that much planning for the child is done. The counselor meets with the educational director and the psychologist to discuss the class placement of the child. Placement entails the selection of the age group and the teacher that would best satisfy the needs of the child. Unless the child is profoundly deaf and requires the specially acoustically wired room, the handicap of the child is not considered in the placement. Our classes are heterogenous with closeness in age a more determining factor in class structure.

After the decision has been made, the teacher meets with the counselor to orient the teacher as to the child's strengths and weaknesses and to formulate a prescriptive educational program. The counselor meets with the parent and teacher to explain to the parent the rationale for the program and how the parent can become actively involved in aiding the child.

The counselor holds conferences with the teacher and parent at regular intervals. These meetings offer the opportunity of making the parent aware of the child's progress and development educationally, socially and emotionally. Occasionally other school personnel attend these meetings. These conferences not only make the parent aware of the child's progress in school but they give the parent the opportunity to discuss and express her feelings and thoughts about the child.

Sessions are held with parent groups to help them in understanding their children and their handicaps. In these group sessions the parent learn that they are not alone or unique. Although the counselor may not play the most active role at these sessions,she may steer the sessions in making the parents aware of the importance of a positive attitude to the child and his handicap. This will develop in the session as the parents ventilate their feelings.

The counselor works closely with the teachers and other school personnel who are meaningful in the child's school life to establish an acceptable environment in which a child can best reach his potential. This is done through many observations of the child in the various school activities, such as the classroom, the lunchroom, and discussion with the bus drivers and the bus matron to learn about the child's behavior and attitude during the ride to and from school.

It is the counselor who acts as the liaison between the child and other school personnel and the many other agencies that are involved with the child and the family. Many of our children are involved in regular medical programs at various medical institutions and social agencies. The counselor keeps these agencies aware of the child's progress and needs.

For many of our children, the Center is an interim school placement. It is the goal of the Center to return as many of our children as possible to the mainstream. The counselor and teacher work towards involving each child in group oriented activities and achieving some measure of success in these group oriented activities. The counselor works with each child to give him inner security to enable him to face new situations.

When the time comes that the child is ready to leave the Center for a less sheltered environment, a conference is held with the school personnel who are involved with the development of the child. It is at this conference that a decision is made about the best possible school or vocational training placement for the child. The parent is invited to come and discuss this future placement.

All the vital material is gathered and readied for the receiving school or training program. The counselor meets with the counselor and other personnel of the receiving school or program to discuss the child. Frequently the child is taken on a visit to his future placement. A follow-up is done on each child to see how well he has adjusted to his new program. This is done by contacting parent and school.

The counselor is school oriented having been a classroom teacher before becoming a licensed counselor. Classroom experience is a prerequisite for licensing. This experience makes her more attuned to the interplay between the teacher and pupil and more sensitive to the group dynamics within the classroom. The counselor can empathize with the teacher and can better feel and understand the teacher's role in the adjustment and the achievement of the child. Therefore, the counselor is most interested in using the curriculum for the child's academic, social and emotional development. She is concerned with how to enhance the child's self-image for future achievement and growth.

A child is a very different person in a group situation with his peers than in a one-to-one situation. The counselor, through demonstration group guidance sessions using various techniques, makes the teacher aware of the dynamics of a group. This information and the use of the techniques are employed by the teacher to better know and understand the children.

The role of the counselor is varied. She works with the parents, teachers, outside agencies and other school personnel to help the child develop his potential academically, socially and emotionally.

CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

The speech therapists evaluate and diagnose speech and language problems, offering intensive individualized corrective programs.

Los teraupistas del Habla evaluan y diagnostizan los problemas que muestra el nino al hablar, ofreciendo programas de correccion individual intensivas.

The occupational therapist helps children in activities of daily living and offers a program of perceptual training.

Los teurapistas ocupacionales ayudan a los ninos en actividades del diario vivir y ofrece un programa de entrenamiento de percepcion.

Para-professionals are indispensable members of the staff and are special friends for the children.

Los Para-Professionales son miembros indispensables del personal y amigos especiales para los ninos.

PHYSICAL THERAPY AT THE CMHC

Olga A. Benitez de Colon, RPT

The Physical Therapy Department occupies one room on the ground floor of the building that houses the Center. The room is ample enough to allow space for a mat table, adjustable parallel bars, one posture mirror to provide visual-feedback, one stand-in table, a mobile weight wagon with dumbells and storage shelves, and storage space for walkerettes, rollators, and wheelchairs. In addition, it has double stall bars, overhead pulleys, one chest pulley weight unit, and one adjustable shoulder wheel, all this as part of the wall equipment. Extra features in the room include one double two-way mirror and a sink. The lighting is appropriately provided by three pairs of fluorescent lights on the ceiling that reach every corner of the room, providing an excellent environment for evaluations and treatment programs.

The physical therapy department also has office space with a desk, one locker and one file where the physical and occupational records and materials are kept. The office space provides a place for the physical therapist to do the administrative work of the position as well as the clerical work related to the clinical part of the position. The physical therapy room is centrally located and easily accessible to and from the other rooms in the Center.

One of the many responsibilities of the physical therapist is the execution of administrative work. A very important aspect of this is the initial evaluation or screening of possible candidates for the Center. This is done in a conference together with the director of the Center, the medical director, who is the direct supervisor of the physical therapist, occupational therapist and the nurse, the occupational therapist, the speech therapists, social worker, guidance counselor, school psychologists and the teacher in charge of the particular evaluation. The evaluation is very detailed and specific, due to the fact that it is used as part of the criteria for admittance to the Center. The basis for admission to the Center must be that the child be multiple-handicapped. Many of the children who are evaluated and/or accepted have some degree of physical impairment. After the child is accepted to the Center, the pediatrician decides if the child needs physical therapy, then he refers him to physical therapy. The physical therapist decides if the child needs to be retested, depending upon the date and the results of the previous evaluations as compared to the actual performance. By interpreting test results (1) the physical therapist is able to design a treatment program for every child who is in need of physical therapy services, taking into consideration the type and severity of the handicap.

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(1) Evaluations consist of: Range of Motion Tests, Reflex Evaluations, Functional Evaluations, and Muscle Strength Evaluations.

Another important responsibility of the physical therapist is recommendations for ordering of equipment such as wheelchairs, walkerettes, crutches, and other equipment or device proper to the physical therapy department. This equipment is to be used by the children either at treatment hours or as a loan until they get their own. The children get their assistive devices, such as, wheelchairs, braces, crutches, etc., from the clinics they attend at different hospitals throughout the city.

A very challenging opportunity for the physical therapist is provided by the supervision of physical therapy students in their clinical practice. Here the physical therapist can put into practice what she or he knows as well as learn new concepts through the interaction with the students. In our case, Hunter College, Institute Sciences occupies the second floor of the same building where the Center is located. The students from Hunter College get clinical training and some of them even volunteer to help not only the physical therapist, but the teachers as well. One example of this was the Christmas party that the students from Hunter prepared for the children of the Center.

Physical therapy treatment is administered based on a system of priorities, due to the different handicaps and the different degree of severity of the handicaps. The most physically involved children get more time and individualized treatment than the least involved. There are exceptions as in the case of very physically involved children whose motivation is very poor. They are seen in a group together with one, two, or more children, in order to provide some type of motivation. The school day is relatively short and there are only eight treatment periods of thirty minutes each, starting from 9:00 A.M. to 12:00 noon, and from 1:00 to 2:00 P.M. The schedule has to be prepared carefully in order to accommodate the largest number of children in one school day. In order to utilize time to its maximum and encourage motivation in some children, the physical therapist with the help of the occupational therapist has formed groups where children with the same disabilities: children with different disabilities but with the same degree of severity, are grouped in classes, such as, ambulation, muscular dystrophy, hemiplegics, etc.

There are two lunch periods: one for the younger children that extends from 11:30 A.M. to 12:00 noon; and another for the older classes that extends from 12:00 noon to 12:30 P.M. In both classes there are children who need assistance or training in feeding activities. Development of independence in feeding is primarily the job of the occupational therapist, but it would be impossible for her to assist all the children in both lunch periods, so an agreement has been worked out where the occupational therapist works in the first lunch period and the physical therapist takes care of the second period. This agreement permits the therapists to use their time more appropriately in order to give the maximum numbers of treatments.

The number of children seen daily depends on the severity of the disabilities treated in that specific day. The normal load for one day is of eight or nine children. That would be forty to forty-five children treated in a week and an average of 170 to 190 children treated over a period of one month.

The physical therapy treatment is not confined to the physical therapy room. Treatment is also administered in the classroom. When a child is not getting any benefit from individualized treatment due to various reasons (for example, lack of motivation, poor interaction, etc.), the child is treated in groups or classes, either in the physical therapy room or in the classroom. This provides motivation as well as encourages the child to work in a group situation. The physical therapist gets help from the occupational therapist, who, apart from being a very able therapist, has made her schedule very flexible so that she can be available and help with the different activities that are worked on with children in a group situation. There are also group activities in the classrooms where the teachers get advice, from both the physical and occupational therapists, as to the follow-up of exercises, both for children who are in P.T. treatment as well as those who do not have any physical limitation; transfer activities, toiletting, etc. Another situation where teamwork is visible is in case discussions with the physical education teacher where a program for the children is set up according to their limitations. The approach has been successful and the success of the therapy program is due to the fact that the staff value highly working as a team.

Among the additional activities where the physical therapist is involved, is a series of group discussions once a week for one hour with a group of twelve of the older girls in the Center. The group meets every Tuesday from 11:00 A.M. to 12:00 noon. Under the auspices of the physical therapist, the occupational therapist and the social worker. Different topics are discussed; for example, the girls' responsibilities at home as well as in school, role playing, etc. The girls interact very nicely and so far the meetings have been very profitable.

The Center for Multiple-Handicapped Children provides a very stimulating environment for the physical therapist as can be judged by the therapist's multiple and varied responsibilities. It is our hope that in the future not only students from Hunter College will benefit from clinical experience in our Center, but that other physical therapy schools throughout the city will also benefit from our services.

OCCUPATIONAL THERAPY AT THE CMHC

Paula Nadelstern, OTR

A main objective for a Center for Multiple-Handicapped Children is to provide children with opportunities to grow and develop to their potential. In order to assist in meeting this objective, the Occupational Therapist provides developmental evaluation, developmental stimulation, and developmental therapy.

During the process of evaluation the child's status is determined in the neuromotor, visual-perceptual-motor, and self care spheres of development. An OT Motor Development Test and the Marianne Grostig Developmental Test of Visual Perception are the standardized tests administered. The Southern California test battery of sensory integration developed by A.J. Ayres has also been ordered and will be used in the future. The physical therapist does most of the testing for muscle strength and range of motion.

When a child is referred to the Center as a possible candidate a joint screening with all of the disciplines participating occurs within a single morning. A formal OT evaluation which evolves from informal observations and modified standardized testing is used in the initial screening because of the limited amount of time and the unfamiliarity of the surroundings to the candidate. In a weekly conference attended by the clinical supervisor, educational supervisor, medical doctor, school nurse, PT, OT, psychologists, speech therapists, social workers, and teacher who tested the candidate, the child's status and disposition is determined.

The OT program maintains a constant evaluation of its role with program revision as indicated. At the beginning of the school year each child is seen as needed for appropriate scheduling and initial evaluations. Children are also referred for OT by the school doctor, both at the beginning and during the school year. The health related services provided by the Center (nurse, OT, and PT), are under the supervision of the medical doctor. The frequency of formal re-evaluation depends upon the child's progress, usually occurring twice during the school year. Initial evaluations of children in the school are kept in the medical record and in the OT - PT file. Continuing evaluative material is also filed into the OT-PT chart. An index file for each child on program with brief summaries is kept on hand for easy reference. A page of every child's educational profile is also filled out by the OT and PT so that the child's status can be easily referred to by the teacher.

The classroom situation provides developmental stimulation. The child is provided with an environment which stimulates all of his senses, and with experiences with his human and non-human environment.

Developmental therapy is an extension of stimulation, and is planned specifically to meet individual needs. The objectives of the individual OT programs are to prevent and correct deformity, to improve physical functioning, to improve ability to function in all self care and daily living activities utilizing devices and equipment when needed for increased independence, to provide a therapeutic climate allowing for socialization and a feeling of worth and accomplishment, and to improve sensorimotor functioning.

The basis for the OT program in cognitive-perceptual-motor dysfunction is that change in sensory-motor integration will enable a person with deviant cognitive-perceptual-motor behavior to adapt more effectively to the environment, and that this change is brought about by controlled sensory input proceding purposeful motor output. The application of sensorimotor treatment approaches in the OT program is not as well developed at this time as it could be. It is hoped that these techniques will develop into a more integral and effective part of the program in the future.

Activities of daily living is an essential part of the program, taking place in the OT room, in the classroom, and in the lunchroom. During the early lunch period with the younger children the OT is responsible for the training and evaluation of the children with eating problems. Many of the more severely disabled children need assistance, which is usually provided by paraprofessionals. The PT shares this responsibility by spending time in the second lunch period with the older children.

Besides the different groups and classes seen during the week, about 25 children, ages 5-18, are seen individually, for 20 minute or half hour periods. The school day is a short one, beginning at 8:40 A.M. and ending at 2:00 P.M. The types of disabilities seen are diversified including combinations of: cerebral palsy (including spastic and athetoid mental retardation, rubella syndrome, spinal-cord involvements, organic brain syndrome, visual problems, speech-hearing-language problems, and emotional disturbance.

In order to meet the above objectives the OT uses meaningful activity which in some instances is known to the child as play. Some of the modalities are crafts, dance and movement, cooking, games, and "rap" groups. An example of the latter in a girls' group made up of 12 girls, 13-17 years old, led by the OT, PT, and social worker. The group is heterogneous in terms of disabilities, including orthopedic handicaps, minimal brain dysfunction, mental retardation, visual problems, speech-hearing-language handicaps, and mongolism. Exploration of different issues (responsibilities, relationships, sex education) is directed toward increased self-awareness and hopefully, perception of self in relationship to others.

At the CMHC there is one OT, and one PT, and 128 children. These statistics automatically determine the need for priorities to be made in terms of treatment. It is essential to alleviate this situation with a productive coordination with the other professionals,by utilizing groups whenever appropriate, and by working as much as possible in the classroom.

Together the OT and PT have created, planned, and implemented a few activity groups. An example is the group which evolved around A.R. an 11 year old mentally retarded boy with Duchennes type of muscular dystrophy. A's behavior during therapy alternated between rocking unresponsively in his wheelchair with his tongue hanging out, and crying during mat exercises. During a consultation with the teacher, PT, and OT it was decided to use this time in the classroom, to demonstrate to the teacher and paraprofessional techniques which could be used to get A and his classmates, none of whom had orthopedic problems, to sit on a mat in the center of the classroom.

The children had been instructed that by participating in the activity they would he helping A. Of course, the activity was structured so that the children benefited in many ways themselves. They played Simon Sez, taking turns helping A stretch to the sky or touch his toes, or a musical sit-down version of the Follow the Leader. A unwittingly did all of the exercises he resisted in the therapy situation. He was now motivated to play with his peers and participate in their games. His classmates enjoyed helping him, and got in the habit of reminding him during the day to keep his tongue in his mouth. When regular breathing exercises were not well received by the group, soap bubbles, from the 5 and 10 were used, thereby obtaining specific treatment from a normal activity. A was motivated to stretch up to pop the bubbles, to count the number of bubbles, and to breathe in the correct way. After about two months during which time A's knee contractures decreased considerably and he learned to keep his tongue in his mouth more often, a new schedule was developed with one treatment session in the classroom and one in a group setting with two other MD boys in PT room. These boys motivated each other to continue the same type of activities which had been going on in the classroom group. This is a good example of implementing purposeful activity which the children view as play, and which was possible through the cooperative effort of the OT, PT, and classroom teacher. When the teacher understands the goals of the OT program he can carry through to reinforce them in the classroom.

Another individual in the setting in a position to reinforce treatment goals is the physical education teacher. It has proven worthwhile to conference with this teacher to familiarize him with the strengths, limitations, and goals of the physically handicapped and neurologically impaired children. The physical education teacher is in a unique position to work with the child's strengths. A large part of the child's program is developed for helping the child overcome his weaknesses. In the home and in the gym the strengths must be capitalized on to build a positive self-image and feelings of confidence.

The parents also must understand the goals for their children in order to augment therapy, particularly in ADL. When the OT began working at the Center she spoke at the Parent's Association meeting, introducing both herself and occupational therapy principles and modalities. When an assistive device is to be used in the home the parent must understand its function and how it is to be used. Since this can not always be done in person, it is sometimes necessary to make a telephone call or to send a note home. Most of the devices are made, when possible, from found objects; when expense is a consideration each situation is decided individually. For the minimal amount of splinting needed orthoplast is used, with a successful arrangement of a hot plate, roasting pan, and hair dryer.

The OT room is a large cheerful room with posters and examples of the children's work on some of the walls. It is set up to provide maximum free space in the Center. There is a work area with a sink for wood-working and similar activities, a desk in front of a full-length mirror for activities requiring visual feedback, a quiet area with two small desks facing the bare back wall providing no distractions, a high mat, a sewing machine, and the therapist's desk and locker placed as a barrier between the work area and the toys and supplies. Along one wall is a two way mirror. The OT room is centrally located and accessible to the rest of the Center. Adequate lighting to all parts of the room is supplied by three large flourescent ceiling lights.

A center of this kind, which is responsive to innovation and creativity, provides opportunities for implementing many OT techniques. It is hoped that in the future the department can provide OT students with a practical experience. At this time two students from NYU have been doing fieldwork in an unstructured manner one day a week here. The OT department intends to continue developing its program and increasing its professional knowledge in order to service the children in the way in which they deserve.

A Story Remembered

By Madeline Dalton

You had to look down to see him but his eyes looked straight out to face the world and its challenges. He received no sheepskin but he was a graduate. He received no honorary degree but he was, perhaps, the most honored of his classmates. His smile encouraged all yet each heart held a tear. Fernando at age seven symbolized a dream for all who came to the Center for Multiple-Handicapped Children "to cross over the bridge" to master the handicaps which challenged their progress and their happiness.

Fernando was the youngest of the first graduating class of CMHC. He walked on crutches and he wore hearing aides but he carried the hopes of all who journeyed to the bridge. He had learned to walk and he had learned to talk at CMHC. No wonder he smiled at this new life. No wonder his classmates cheered as he exchanged a kiss for his diploma. If he could cross over the bridge and cope with life in the mainstream of the school system, then surely there is hope for all. Fernando is doing that now and so too, are the many graduates of CMHC.

In 1965 CMHC was only a dream and a concept. In 1971 it was a reality under ESEA Title III funds. In 1972 it was accepted on full tax levy status by the Board of Education and the Board of Estimates. It is now a regular part of the permanent budget for Special Education in the City of New York. It is also a National Demonstration Model Program selected for its unique services for very special children.

It all began in the Spring of 1968 when the Special Education Bureaus of the New York City Board of Education were invited to submit proposals for innovative programs under ESEA Title III guidelines. About one million dollars were available but the proposals would be competitive throughout the state. Each bureau could submit separate proposals to zero in on its own special needs or all could join forces in one major innovative effort.

Since it was late in the school year there was little enthusiasm for any major staff efforts in preparing proposals that seemed to hold such slim chance of success in such a competitive field. The time was right, therefore, for wide acceptance of my suggestion that we join forces in requesting a maximum service center for the multiple-handicapped children who had been the concern of a special inter-bureau committee for the past seven years. "Great idea," they agreed, but who would write the proposal. Delighted with the prospects and unmindful of the obstacles ahead, I accepted the challenge. How better to insure my ideas and philosophy and bias. My proposal would not exclude any child because of I.Q. For who shall say wherein lies the major handicap when a child has many! No where was there more rejection than for the child whose multiple handicaps included retardation. Yet who could say which intervention might change that picture and prognosis.

With a sense of urgency and not too much enthusiasm a small committee met immediately after the larger conference for about an hour. Representatives from the non-public schools, Jim Rinaldi (Bureau of Child Guidance), John Harrington (Language and Hearing Impaired), Grace McCandless, (Bureau for the Education of the Physically Handicapped) joined with me to refine the concepts, hammer out appropriate staff and service ratios and to identify a composite picture of the very special children who had slipped between the categories in special bureau and inter-bureau programs.

The design, the rationale, the objectives, the school statistics and the proposed budget would come later. How lucky I was to have Dr. Edmund M. Horan, Acting Assistant Director on the Bureau CRMD staff in charge of funded programs. He was willing, thorough, capable and optimistic. He carefully reviewed and outlined the Title III guidelines. As we prepared the application, I systematically checked off the obstacles to placement which had challenged the Inter-Bureau Multiple-Handicapped Committee over the past seven years, for I was determined to devise an organizational pattern and screening policy which would include rather than exclude, which would group children on the basis of physical management problems and current comprehensive needs for educational intervention rather than on the basis of handicapping categories or projected learning capacity. Who was to judge whether a physical or mental handicap offered the greater obstacle to learning? Who was to say which intervention might provide the catalyst for new avenues of learning and achieving?

As the design took shape we became more and more enthusiastic about the possibilities of a total service program which could offer an honest effort at rehabilitation for those whose potential had not yet been fully explored to offer real hope to discouraged and disheartened parents who had traveled the route of referrals and services which were non-existent, inadequate or located all over town.

Ida Silver, Coordinator of funded programs for the then Office of Special Education and Pupil Personnel Services under Assistant Superintendent Richard Lubell, reviewed our data and checked the details of the application to be sure that every guideline was met before review and approval of the full committee. We were pleased with the concept and the design but we could hardly comprehend the figures when Dr. Horan completed the budget which amounted to three and one half million dollars over a three year period. It was rather like making a magical wish where hopes and dreams could come together but without any assurance of an Aladdin's Lamp to wish upon. The job completed, we were off to the real and pressing needs with our dreams stored away for the summer.

Who could have anticipated the events of the Fall of 1968! The United Federation of Teachers was on strike. The Council of Supervisors and Administrators was in support. Schools and offices were alternately opened and closed. Pickets took up their vigil in front of all public school buildings.

Somehow, in the midst of all this, we received approval of our application for a Title III grant for a Center for Multiple-Handicapped and somehow, we had to complete the full proposal and meet the deadlines. When buildings were opened Ed, Ida, and I worked in the Bureau CRMD office's on Pacific Street. When buildings were closed we met at the Board of Health or in Ida Silver's home. In between we managed to get each day's efforts to my secretary, Ida Cooper, who kept pace with our frantic race against the deadlines. Statistics were gathered, letters of support from community agencies were selected, an advisory committee was convened for which Dr. Donna O'Hare accepted the chairmanship, and, finally, with Mr. Lubell's blessings and support we secured Superintendent Bernard Donovan's signature and the Board of Education's approval.

With the ink still damp on the copies, Dr. Horan hand delivered the twenty five copy packet to the bus depot for fast and sure delivery in Albany in time for the Title III review deadline.

The rest is history. A trip to Albany to justify all objectives and objections before the Title III Committee, a three and one half million dollar commitment, a planning period, the search for a proper location, the contract maze, construction delays, housing codes, staff selection screening procedures, pupil selection, home visits, bus contracts and opening day.

Because a dream is only as real as its interpreters can make it, because unconscious bias and prejudice could readily shift the original focus and objectives, it was extremely important that the leadership role for the Center be placed in the hands of truly dedicated and committed special educators who saw potential in the most handicapped child, who measured success in individual growth rather than group statistics, whose philosophy could reach out and take in, not rule out or exclude. Dr. Edmund M. Horan was my first and only choice for Director of CMHC even though BCRMD could ill afford to lose him. The screening team accepted the recommendation and added two fine assistants. Gerald Ehrlich, long associated with the Inter-Bureau Multiple-Handicapped Committee was the uncontested committee recommendation to establish and coordinate clinical services and develop intake procedures. Dr. Al[illegible]n Schulps, highly endorsed by Marcus Arnold, Director BEPH, joined him as Special Education Coordinator of CMHC. Dr. Alfred Scherzer was soon confirmed by the complete advisory committee as the pioneer Medical Director for the new center. On his last official day as Assistant Superintendent OSEPPS, Mr. Richard Lubell confirmed these recommendations and made the official appointments in appropriate titles. How proud he must be to have assigned such a legacy to CMHC! How fortunate are all the Fernando's!

It has been a long road with many firsts. A beautiful staff and an unmatched Parents Association have together made all the dreams come true but there are still many children making magical wishes. We must continue to extend and expand the magic of CMHC until all who need its comprehensive services can find a welcome at the door and Aladdin's Lamp within.

CENTER FOR MULTIPLE-HANDICAPPED CHILDREN

SCHOOL BUS
COLONIAL BUS SERVICE INC

Children are bused to the Center from the boroughs of New York City ghrough the services of the Bureau of Pupil Transportation.

Los ninos son transportados al Centro desde todos los contados de la siudad a traves de los servicios que provee el "Bureau of Pupil Transportation."

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